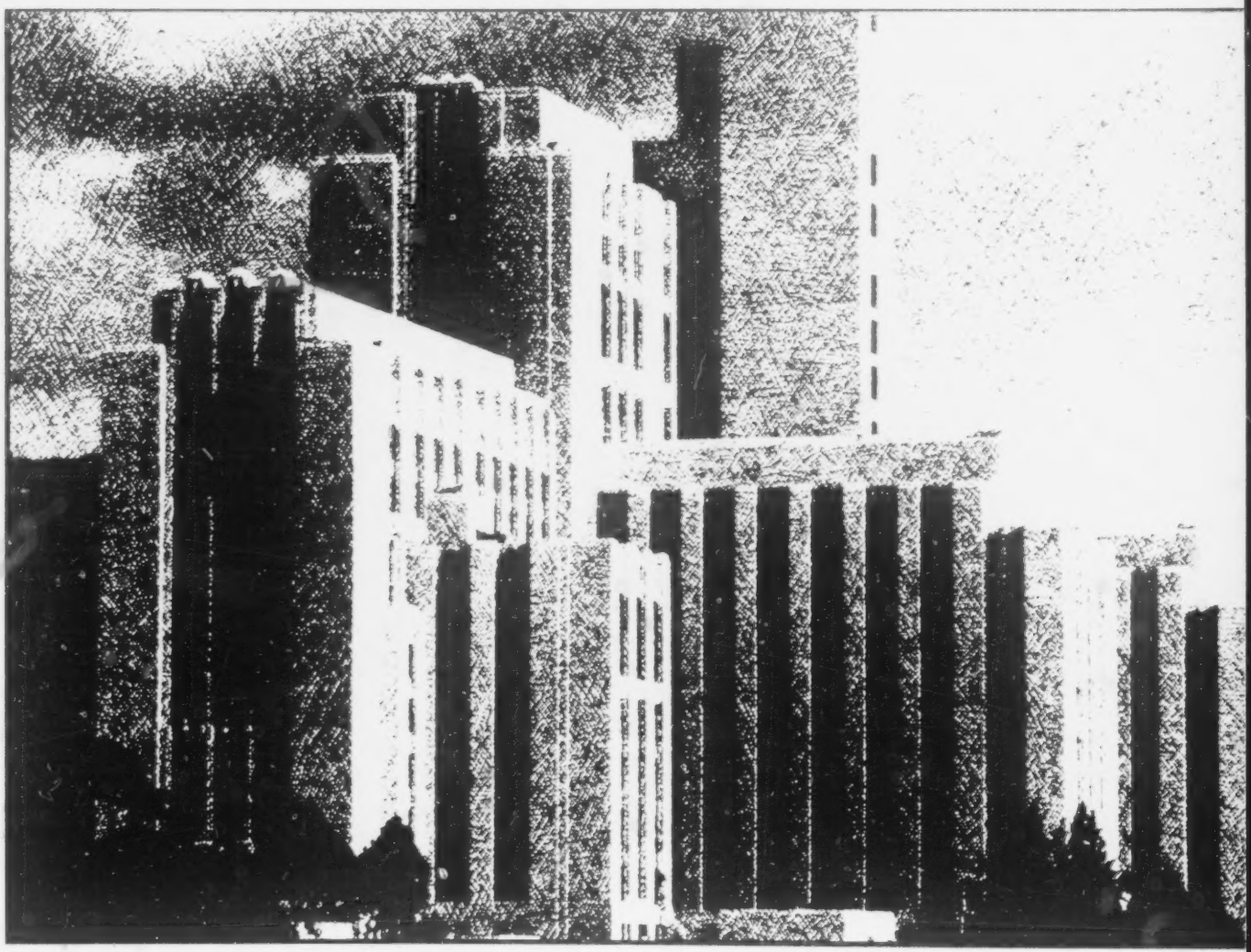
AMERICA'S SAFETY NET HOSPITALS: The Foundation of Our Nation's Health System

NATIONAL ASSOCIATION OF PUBLIC HOSPITALS



January, 1991

AMERICA'S SAFETY NET HOSPITALS

THE FOUNDATION OF OUR NATION'S HEALTH SYSTEM

**A National Association of Public Hospitals
WHITE PAPER on the Situation of
Safety Net Hospitals in America Today
with an Action Agenda for the 1990s.**

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January, 1991

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Introduction

The 1990s will be a time of crisis and opportunity for our nation's health system. The **CRISES** of the 1990s will be fueled by the continuation of several current health system trends:

- the continuing (and expanding) need for access to health services by uninsured Americans;
- our nation's indefensible failure to reduce infant mortality, and to close the gaps in health status, morbidity and mortality rates among many low income populations;
- the growing need for health services by special populations such as AIDS patients, drug abusers, the homeless and victims of trauma and violence;
- the escalating fiscal and economic pressures at all levels of government, that will continue to lead to pressures to reduce spending or ration resources in Medicare, Medicaid and other public health programs;
- the spiralling fears of employers that health care costs are too high, and are rising too rapidly, both in real dollars and as a percent of overhead and profits; and
- the increasing reluctance, due to reimbursement and competitive pressures, of many private health care providers to serve uninsured patients and other patients with special needs.

Despite these trends and pressures, extraordinary **OPPORTUNITIES** are also likely to be available in the coming decade—at least for those providers in our health system who can respond effectively to these crises.

- Notwithstanding the current vigorous national debate over "quality and cost", the overall quality of health care in America is still the best in the world.
- Biotechnology promises to provide us with a new generation of drugs and pharmaceuticals that will revolutionize prevention and treatment in many areas—if we can reorganize our health system to afford them.
- There is at last a widespread realization that the burden of caring for millions of uninsured and underinsured Americans is distributed unequally, and in the future there may well be considerably broader support for expanding access and coverage for these individuals.
- Finally, by carefully nurturing reforms in health service delivery, such as the development of regional networks, vertically integrated health systems, managed care, and cost effective outpatient services, we may even be able to keep overall health costs in line as we expand access and coverage.

A common misconception with respect to our nation's health system is that we lack the resources to *both* expand access for the uninsured, on the one hand, and preserve the quality of care most Americans have come to expect, on the other. Nothing could be farther from the truth. Overall health spending exceeded $600 billion in 1990—up from $230 billion in 1980—and annual per capita spending approached $2,600—or over $10,000 for a family of four! Even the most conservative observers estimate that those figures will double by the year 2000. The American Academy of Pediatrics estimates that providing a basic benefit package for the nation's 10 to 12 million uninsured children would cost just $458 per year per child. Most assuredly, we do not lack for resources to undertake such a task—assuming we can bring greater discipline to the way our health resources are spent. We don't even have to reallocate current funds, if we can find the leadership to obtain agreement to devote a small proportion of our nation's projected **increased health spending** to filling health coverage gaps and meeting unmet needs.

Why Do Americans Have the Luxury of Debating, Rather Than Acting On, Universal Health Access?

A small group of metropolitan area hospitals makes up our nation's institutional health safety net today. We do not believe that it is inappropriate to refer to them as the very foundation of our nation's health system. This White Paper is a report to the nation on the precarious situation of these hospitals today—on their mission, services, finances, and on their policy agenda for the future.

Recognizing the Importance of Safety Net Hospitals. The National Association of Public Hospitals (NAPH) has for the last decade represented a significant proportion of America's metropolitan area safety net hospitals. Today, NAPH members include 100 hospitals. This may seem like a small number, in a country that boasts over 6000 acute care hospitals. But these 100 institutions (taken together) comprise America's (and the world's) most important health and hospital systems. With combined gross revenues of over $10 billion, these major, tertiary hospitals truly serve as "national health insurance" by default, in most of our nation's metropolitan areas.

NAPH has reported to the nation twice before—in 1982 and 1987—on the situation of these essential providers. Each time, the Association warned of an increasing reliance by uninsured patients on this small group of safety net hospitals—and a corresponding weakening of their programs and financial situation. In each of those reports, NAPH called for a number of health system reforms aimed at improving the situation of both these safety net institutions and the patients they serve.

While some of the reforms called for by NAPH in previous reports have since been adopted, the new data set forth in this White Paper makes clear that the situation of many safety net hospitals has continued to deteriorate. Gratifyingly, since 1987 the Congress has adopted significant expansions in the Medicare disproportionate share hospital (DSH) adjustment and mandated states to adopt DSH payment increases in their Medicaid programs. But while nearly $2 billion per year now flows through these mechanisms (to about 1,600 hospitals in all), Medicare remains a relatively small proportion of the income of many safety net hospitals, and fully half of the states have so far failed to adopt meaningful Medicaid DSH adjustments. In many of these states, even the base Medicaid payment rate is neither reasonable nor adequate. As a result, the proportion of Medicaid revenues at most safety net hospitals has actually declined, while the number of uninsured patients has increased.

This situation has increased the need by safety net hospitals for direct subsidies by local (and in some cases state) governments. However, in many cases, state and local budget crises and taxpayer revolts have left such governments unable or unwilling to meet the full need for direct subsidies. At the same time, there has been a significantly increased demand for services in the 1980s by many new populations of safety net patients, including persons with AIDS, the homeless, drug abusers, trauma victims, and high-risk pregnant women.

These factors have further eroded the viability of many safety net hospitals. As they scramble to meet the acute needs of patients with these new morbidities, there are no additional resources. Such resources are especially needed to expand primary and preventive care, seek community-based solutions or obtain access to capital funding for maintenance, new technologies, and renovations. This is unfortunate as the expansion of these latter programs could reduce overall costs.

The purpose of this third NAPH White Paper is thus to educate health policy-makers, other providers, and the public on the most important trends and pressures affecting the safety net. It will do so by

The NATIONAL PUBLIC HEALTH AND HOSPITAL INSTITUTE (NPHHI) is a private non-profit research foundation established in 1988 by the National Association of Public Hospitals (NAPH) to address—through research and education—the major policy, fiscal and management issues facing the nation's metropolitan area public and non-profit hospitals. NPHHI is the first national research organization to focus specifically on the concerns of "safety net" hospitals—those which serve a disproportionate number of low income patients.

NPHHI evolved in response to the recognition that safety net hospitals, which serve as major referral centers, teaching hospitals, and hospitals of last resort for the poor, are unique in many ways within the hospital industry. NPHHI is compiling and reporting information on these hospitals and their experiences with AIDS, drug abuse, primary care, emergency department crowding and other pressing public health issues. Institute publications on these and other topics have already been widely read and cited, both nationally and internationally.

Government and private supporters of NPHHI research projects have included the Robert Wood Johnson Foundation, The Pew Charitable Trusts, the Commonwealth Fund, the Centers for Disease Control, the Agency for Health Care Policy and Research, the Health Resources and Services Administration and the American Foundation for AIDS Research.

The Institute, in collaboration with NAPH, developed the first management education program in the country designed specifically for public hospital executives. Established in conjunction with the New York University Wagner School of Public Service and the Pew Charitable Trusts, the program is open to selected senior officers of metropolitan area hospitals.

Building coalitions with universities and national associations is another unique strength of NPHHI. This broad-based approach allows NPHHI to expand the scope and applicability of its research. In this regard, the Institute orchestrated a national AIDS research coalition that includes the Council of Teaching Hospitals (COTH), the Catholic Health Association (CHA), the National Council of Community Hospitals (NCCH), the National Association of Children's Hospitals and Related Institutions (NACHRI), NAPH, and the National Rural Health Association (NRHA). NPHHI has also conducted a comprehensive national study on the status of emergency and trauma care, which includes collaboration with COTH and NAPH. NPHHI is currently in the process of building working relationships with countries and related associations in the European Community and Eastern Europe.

providing a snapshot of the relative health and viability (or lack thereof) of these hospitals today, both as a group and in many cases individually. And it will also describe, and lay the groundwork for enacting, the significant additional health system reforms that will be required in the next decade by safety net hospitals and the millions of patients they serve.

The remainder of this introductory chapter will summarize the situation of our nation's health safety net today, by underscoring (and putting into context) some highlights of the substantial amount of detailed information that is contained in the body of this report. This will be accomplished through a series of general statements applicable to safety net hospitals, with each statement illustrated by key facts drawn from the text of this report. (Data presented in this summary, and throughout the White Paper, are based on a comprehensive survey of the characteristics of 60 NAPH member hospitals in the calendar year 1988, augmented by the annual U.S. Hospital AIDS Survey of the National Public Health and Hospital Institute (NPHHI), other NAPH and NPHHI research, the American Hospital Association's Annual Survey, and other organizations.) Following the chapters setting forth NAPH's detailed data and analyses, an NAPH agenda for health system reform in the 1990s is provided in Chapter 12.

The Need for America's Safety Net Hospitals in the 1990s Will Be Greater Than Ever.

Only 75% of Americans have private health insurance in America today. The rest of the population relies on a patchwork of federal, state and local programs to pay for its health care. At the federal and state levels, public health insurance is primarily offered through the Medicare and Medicaid programs. These two programs, however, only serve individuals meeting specific eligibility criteria. As a result, over 33 million indigent Americans have no health insurance, and many millions more are only partially insured.

The need for health services by uninsured indigent patients continues to escalate dramatically—and the present weakening of the American economy can only increase this demand. At the same time, competitive and reimbursement pressures on most private sector providers have been severe. Private insurers, Medicare and many state Medicaid programs have demanded and received substantial cost concessions from hospitals, physicians and other providers. Hospitals have been particularly hard hit because they have also been faced with substantially increased competition from non-hospital providers—often including their own medical staff. As a result, many private hospitals in the 1980s have aggressively sought ways to reduce services to uninsured, "safety net" patients. Emergency department closures—trauma center decertifications—the abandonment of high risk tertiary services—the curtailment of outpatient services—these private sector actions have increased pressure tremendously on county hospitals and other safety net providers.

Quite simply, the willingness and ability of private providers to shift the costs of uncompensated care to privately insured individuals has been significantly eroded in recent years. As Princeton economist Uwe Reinhardt has said: "Cost shifting has served as a fig leaf to cover up what would otherwise have appeared to the world as a national disgrace. The fig leaf, alas, appears to be slipping."

The Volume of Services Provided by Safety Net Hospitals Continues to Increase, and Overcrowding Is Becoming a Serious Problem in Some Institutions.

The average NAPH member hospital had 526 beds and admitted almost 20,000 inpatients in 1988, representing almost 160,000 inpatient days. NAPH members experienced an average of over 71,000 emergency department and 190,000 outpatient department visits in 1988. NAPH member hospitals also delivered an average of more than 4,000 babies. Some NAPH member hospitals experience as many as 400,000 clinic visits and 15,000 births annually.

53% of all admissions to NAPH safety net hospitals were through the emergency department in 1988 (more than 70% for some hospitals), and many emergency and clinic patients are waiting longer to see doctors or be admitted. 58% of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours. Because of the saturation of primary care and outpatient services at many of these institutions, the emergency room has inappropriately become the family doctor for many indigent people.

A Substantial Proportion of the Patients of Safety Net Hospitals Are Uninsured, and Their Number Is Growing.

Over 30% of inpatient days and 52% of outpatient visits to NAPH member hospitals were by uninsured patients in 1988. This represents over 2.9 million inpatient days and 6.9 million uninsured outpatient visits, including emergency department visits. 36% of inpatient days and 25% of outpatient visits were by Medicaid patients; 19% of days and 13% of visits by Medicare patients, and only 15% of days and 10% of

visits to safety net hospitals were by patients with private insurance. The proportions of privately insured, Medicare and Medicaid patients have decreased in the last several years, while the proportion of uninsured has increased.

- **NAPH hospitals averaged $147.2 million per hospital in net revenues in 1988.**
- **30% of inpatient days and 52% of outpatient visits in NAPH hospitals in 1988 were for patients with no source of payment.**
- **The average NAPH hospital had a negative operating margin of more than $9 million.**
- **The average NAPH hospital provides 71,026 ER visits, 190,744 clinic visits and 19,968 admissions annually.**
- **Occupancy rates in NAPH hospitals are high (over 80%) and continue to rise.**
- **Bad debt and charity care as a percent of charges increased from 22% in 1982 to 42% in 1988.**

Safety Net Hospitals Are Losing Money on Every Category of Patients They Serve; Just 57 NAPH Member Hospitals Lost More Than $530 Million Through Operations in 1988.

Fifty-seven NAPH member hospitals recorded gross revenues (charges) of $10.3 billion in 1988. However, 35% of these gross charges were attributable to uninsured ("self pay") patients. Net operating revenues (including direct local subsidies in addition to patient care revenues) totalled only $8.1 billion.

Gross charges for Medicaid patients in safety net hospitals averaged nearly $55 million per hospital in 1988, while collections averaged only $39.8 million. Gross charges for Medicare patients averaged $33.6 million in 1988, while Medicare collections averaged only $24.7 million. The average safety net hospital even lost money on its few privately insured patients, averaging $30.8 million in charges but just $25.7 million in collections.

Average NAPH member hospital gross charges were highest ($63.2 million) for "self pay" patients—a population from whom patient care collections were also lowest ($15.5 million, or just 24.6%).

As a result of this bleak revenue picture, NAPH member hospitals averaged operating deficits of over 30% in 1988 before direct subsidies are taken into account; even with direct subsidies, NAPH members averaged deficits of $9.4 million, or approximately 6%. When net operating revenues (including subsidies) are compared with operating costs, 57 NAPH member hospitals experienced a total shortfall of $534 million in 1988. This operating shortfall was made up in many instances by deferring maintenance or needed capital purchases, through layoffs (or the inability to fill staffing vacancies), and through other extraordinary means. In some cases, requests for direct state or local subsidies were increased in the following year to make up the shortfall, but these requests were by no means always honored.

Local Government Plays a Significant Role in Funding the Health Safety Net, and the Proportion of Care Funded by Local Government Has Risen.

As the data summarized above underscore, many city and county governments (and a few states) play a significant role in directly subsidizing the uncompensated care provided by America's safety net hospitals. Total direct subsidies to 57 NAPH member hospitals amounted to $1.665 billion in 1988. This exceeded total Medicare collections ($1.406 billion) and total private insurance collections ($1.389 billion) by these hospitals.

Nationally, it has been estimated that cities, counties and other local governmental entities contribute upwards of $12 billion annually to subsidize direct patient care for the uninsured poor. One recent study found that cities or counties in 54 metropolitan areas contributed an average of over $30 million each to indigent hospital care.

During the 1990 debate over Medicare and Medicaid spending reductions, it was implied by some private sector hospital lobbyists that increased DSH payments under those programs have resulted in reduced local commitments. Yet nothing could be further from the truth. In many urban areas, direct city, county (and in some cases, state) subsidies have in fact **increased along with Medicare and Medicaid payments** in recent years. Although safety net hospitals received an increased Medicare DSH adjustment in 1989, for example, Los Angeles County actually found new revenue sources to increase the direct subsidy to the county hospital system by $60 million. In Louisiana, direct state subsidies to Charity Hospital of New Orleans increased by $48 million. And direct subsidies also increased last year in New York City, Kansas City, Atlanta, Washington D.C. and elsewhere.

Many Safety Net Hospitals Receive Little or No Direct Subsidies.

Of more than 1500 hospitals that receive a Medicare DSH adjustment, at least 250 provide **significantly** disproportionate services to low income patients.

Many of those 250 hospitals—perhaps even a majority—are public or nonprofit providers that maintain their "open door" safety net mission with little or no benefit of subsidies. This is due in some cases to their private status, but even for many public hospitals, the local tax base is limited by the size of the population, the state of the local economy, or state constitutional taxing limits. If these hospitals receive subsidies at all, their payments have often been capped for years at relatively low levels. Examples of such hospitals, which must finance their operations primarily from Medicare, Medicaid and other third party revenues, include the University of New Mexico/Bernalillo County Medical Center, Memorial Medical Center of Savannah, Pontiac General Hospital, Seattle's University Hospital/Harborview Medical Center, Minneapolis' Hennepin County Medical Center, Chattanooga's Erlanger Medical Center, Amarillo's Northwest Texas Hospital, the University of Nebraska Hospital, St. Luke's Roosevelt Medical Center, the University of Chicago Hospitals—the list is a long and distinguished one.

Despite Statutory Mandates and Increased Congressional Attention, Hospital Payments by Many State Medicaid Programs Remain Woefully Inadequate.

The proportion of subsidies required by NAPH member hospitals often varies in direct proportion to the adequacy of the Medicaid program in a state. Some of the very highest direct subsidies in 1988 were recorded in states (like Texas and Louisiana) with inadequate Medicaid programs. The ten NAPH member hospitals with the highest proportion of direct subsidies (50% to 80% of revenues) had Medicaid payments of 9% to 38% (with most Medicaid payments at the lower end of that range). In the facilities of the New York City Health & Hospitals Corporation, where a relatively strong Medicaid program accounted for 33% to 62% of hospital revenues, direct subsidies (though still significant) were considerably lower (at 22% to 32% of revenues) than in the low Medicaid states. The same was largely true in Massachusetts, Washington, Michigan, Georgia and other states with adequate Medicaid hospital payment methodologies.

Dramatic differences in the adequacy of Medicaid payments can be seen by comparing net Medicaid revenues with gross Medicaid charges in a number of states. While NAPH member hospitals in Texas, Pennsylvania, California and Arizona collected just 34% to 65% of charges from the Medicaid program, most NAPH members in New York, Massachusetts, Washington, Michigan and Georgia reported collecting 80% to 100% of charges. While this report uses 1988 data, NAPH believes that these trends have continued in many states despite the explicit statutory mandate that states adopt meaningful DSH adjustments. This has resulted in considerable litigation in some states involving the overall adequacy of Medicaid payments. NAPH data shows that fewer than half of all states have adopted meaningful DSH adjustments to date.

NAPH member hospitals have even assisted some states in developing new sources of revenues to enable those states to expand their Medicaid programs and improve payment rates. Such sources have included soliciting voluntary donations by providers and others, adopting taxes or license fees on hospital revenues to fund indigent care pools, or arranging for the more aggressive participation of local governments in funding state Medicaid programs.

The Needs of Special Populations Have Continued to Dominate the Mission and Programs of Safety Net Hospitals, and to Cause Financial Hardship.

Special populations include persons with AIDS, drug abusers, trauma victims, the deinstitutionalized mentally ill, the homeless, and other low income patients in need of long term or home care. For example, in a survey of 15 NAPH member hospitals, it was determined that 29% of all emergency department visits were drug-related in 1988. In the sample selected, during a one month period, 4,583 individuals had drug abuse as their primary diagnosis, while in 14,066 cases, drugs were a complicating factor in these safety net institutions. One hospital (Harbor/UCLA Medical Center) reported that 67% of all emergency department visits on one evening were drug or alcohol related.

Another survey of 30 NAPH member hospitals reported an average of 104 cocaine-addicted newborns per hospital in 1988, and 61 for the first half of 1989—a 17% increase. D.C. General Hospital reported that 20% of all newborns during the period surveyed in 1988 and 1989 tested positive for illicit drugs, while Los Angeles County's King-Drew Medical Center reported 600 cocaine-exposed infants in 1988 and 325 in the first half of 1989.

In the case of the homeless, one NAPH member (Bellevue Hospital Center) estimated that 20% of all inpatients were homeless at discharge, and that such patients required stays that were twice as long as other patients. Among 19 NAPH members surveyed, 6% of all inpatient days were taken up by so-called "administrative" patients—patients able to be discharged but who had no place to go. This represents an average of 11,284 days per hospital.

Safety net hospitals in border states also experience special problems serving large, primarily illegal, immigrant populations.

The Role of NAPH Member Hospitals in the AIDS Epidemic Has Continued to Escalate in Scope and Importance.

The number of AIDS inpatients treated in NAPH member hospitals has tripled since 1985, from 2,977 patients and 4,267 admissions, to 9,495 inpatients and 15,526 admissions in 1988. Inpatient days during that period increased from 91,094 to 276,220. NAPH member hospitals continue to lose money treating AIDS patients, losing an average of $4,903 for each admission. Losses for the 15,626 admissions to NAPH hospitals totalled $76.6 million in 1988. The financial situation is particularly troublesome in those parts of the country where Medicaid coverage is inadequate. This is graphically illustrated by examining the extent of Medicaid eligibility by region: 70% of AIDS patients were covered by Medicaid in the Northeast and 66% in the West, as compared with 44% in the Midwest and just 25% in the South. Conversely, only 10% of all AIDS patients in the Northeast were "self pay" patients, as compared with 23% in the West, 25% in the Midwest, and a whopping 61% in the South.

Average length of stay for AIDS patients has been slowly decreasing in NAPH member hospitals, as treatment has become more widely available outside of hospitals. ALOS decreased from 21.3 to 17.7 days between 1985 and 1988 nationally. However, the availability of alternative treatment modalities was much more highly developed in the West, where ALOS was just 10.9 days, than in the Northeast, with an ALOS of 24.2 days. (This difference is also partly accounted for by the much greater proportion of low income, minority drug abusers among Northeast AIDS patients.)

Sure, You Can Get Sick—But Not Too Sick

Like most people with health coverage, John McGann didn't worry much about the high cost of medical care. Even when the Houston music store employee came down with AIDS in December, 1987, he was confident his medical bills would be paid.

Eight months later, his employer, H&H Music Co., announced it was switching health plans. The new one would impose a $5,000 lifetime ceiling on AIDS-related coverage while keeping the cap for other illnesses at $1 million. "I felt betrayed," says McGann, 47, who adds that he has $20,000 in AIDS-related medical bills that he can't pay. He has sued H&H and General American Life Insurance Co., which administers the plan.

Business Week December 3, 1990

Despite These Many Problem Areas, Safety Net Hospitals Continue to Offer the Very Highest Quality of Health Care, With Strong Programs of Medical Education and the Continued Growth and Development of Many Areas of Excellence.

Notwithstanding the threats to survival spelled out above, and throughout this report, many safety net hospitals continue to offer the very highest quality of medical services available anywhere in the hospital industry. These include high-cost tertiary services, such as trauma care, burn units, and neonatal intensive care, and high quality primary care. For example over three-fourths of NAPH member hospitals have trauma centers, as compared with just 13% of all hospitals nationally, and 78% of those are Level I centers.

In part, this concentration of specialty services is due to the important medical education role NAPH members continue to play, which guarantees a strongly committed and competent medical staff at all levels. NAPH members on average trained 191 residents in 1988, or over 7,500 in all (this represents 12% of all residents trained in America). A significant number of these resident physicians stay to continue working in NAPH member hospitals or in other public-sector settings.

Successes have been achieved by many safety net hospitals in developing and marketing specialty services as "Centers of Excellence" to private patients in addition to the uninsured or others with special needs. These successes can be traced in part to the extraordinary medical and administrative leadership to be found in these hospitals. As the innovative programs described in Chapter 11 clearly illustrate, physicians, nursing staff, and administrators of NAPH member hospitals can be as creative as they are dedicated and compassionate. Leadership has also been evident in the area of Medicaid managed care programs. Successful public sector managed care plans have been developed in Contra Costa County and San Mateo County, California; Minneapolis and St. Paul, Minnesota; Phoenix; Miami; and elsewhere.

In conclusion, America's safety net hospitals have been able in the 1980s to respond to financial pressures and increased demand through a combination of services, leadership, and sufficient financial support from a variety of sources to keep most of their doors (and services) open. This White Paper is thus also intended to be a tribute to the fine work these hospitals have accomplished in the past—as well as an effort to provide hard data and analytical support for the reforms that will be needed to guarantee their survival in the future.

Profiles of NAPH Member Safety Net Hospitals

While most of this White Paper in given over to summary nationwide findings on the situation of safety net hospitals, the vital importance of these hospitals can perhaps best be illustrated with a brief description of each NAPH member institution. This, then is an overview of the individual institutions that make up America's health safety net.

Bellevue Hospital Center, New York, NY
New York City Health and Hospitals Corporation

One of two hospitals that lay claim to being the nation's oldest public hospital (See Charity Hospital below), 1,226-bed Bellevue is the largest single hospital building in the world, a 25-story high rise. The hospital is a certified heart station, a trauma center for head and spinal injuries, and a major receiving center for the reimplantation of severed limbs. Its satellite AIDS Assessment Program helps coordinate and centralize access to medical services for patients at highest risk for the disease. Bellevue is the city's leading institution for emergency care. It operates a 10-bed intensive care unit within its emergency department. The mobile emergency department vehicle, the Manhattan Disaster Bus, responds to situations involving multiple casualties. The High Risk Infant Transport Service, another citywide service, maintains two special ambulances that are intensive care units on wheels.

Bexar County Hospital District, San Antonio, TX

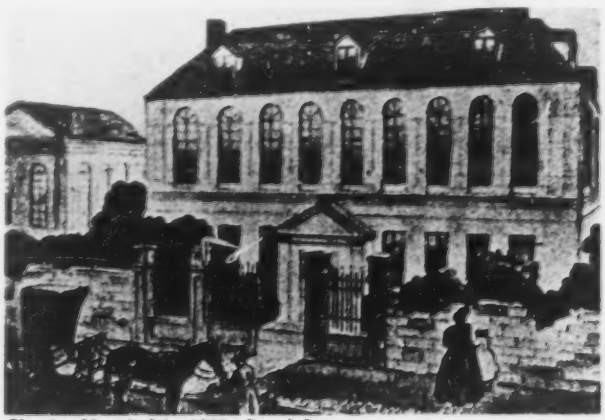
Formed in 1955, Bexar County Hospital District is a tax-supported health care organization now consisting of Medical Center Hospital and the Brady/Green Community Health Center. Medical Center Hospital is a 550-bed acute care hospital specializing in emergency medicine, neonatology, organ transplantation, pediatric cardiac surgery, high-risk obstetrics and other areas. Medical Center Hospital's Emergency Center is the only civilian Level I trauma center in Bexar County. With more than 270,000 outpatient visits each year, Brady/Green Community Health Center is ranked among the busiest facilities of its kind in the state. The facility was originally built in 1917 to care for the medically indigent in Bexar County. With the opening of Medical Center Hospital in 1968, the Brady/Green changed roles as primarily an outpatient health care provider. Today, Brady/Green offers treatment in areas including pediatrics, allergy, dermatology, orthopedics, urology, and diabetes. The center also offers full-scale prenatal care for normal, diabetic and high-risk pregnancies through the Obstetrics and Gynecology Clinics.

Brackenridge Hospital, Austin, TX

First constructed in 1884 as a 20-bed, two-story facility, Brackenridge Hospital has developed into a major medical center of 372 beds. In 1988 an adjoining 82-bed Children's Hospital of Austin at Brackenridge opened, providing the most advanced pediatric facilities in the surrounding area. Brackenridge Hospital provides a wide range of specialized medical care and diagnostic services. The acute care facility hosts a maternity center, a 25 bed ICU, and a pediatric ICU. As the Regional End Stage Renal Unit, Brackenridge is Medicare-approved for kidney transplants as well as for obtaining donor kidneys and other organs. The hospital established the first alternative birth center in central Texas in 1976. With its Level III neonatal ICU, Brackenridge also provides the highest level of care for newborns. As the only Level I trauma center within a 10 county radius, Brackenridge handles major emergency illness and trauma for the central Texas region.

Bronx Municipal Hospital Center, Bronx, NY
New York City Health and Hospitals Corporation

Bronx Municipal Hospital Center was built in 1954 as the new general hospital and tuberculosis hospital in the East Bronx. The 776-bed hospital provides many special programs. Since 1982, BMHC has been designated a Level I trauma center. A unique aspect of the Trauma Center is its designation as the Regional Snakebite Center, in cooperation with the herpetology staff of the nearby Bronx Zoo who provide consultation and anti-venom serum. The Burn Service, first established in 1961, is the only burn service in the Bronx. BMHC is also designated as the hyperbaric center, treating victims of smoke inhalation and carbon monoxide poisoning at the North American Hyperbaric Center. Since June 1986, BMHC has run a pediatric AIDS day care center providing both education and clinical support for children with AIDS. This was the first such program begun nationwide.



Charity Hospital in 1815, Canal Street

Charity Hospital, New Orleans, LA

The original Charity Hospital was established in 1736 by a bequest from a French seaman and merchant named Jean Louis. Today the 645-bed hospital

delivers clinical services through nine hospital centers and is part of the Louisiana Department of Health and Hospitals. Admission priorities are given to the indigent, with those able to pay admitted on a space available basis. Special inpatient care is available for leukemia patients, psychiatric emergencies, cancer therapy, spinal injuries and major rehabilitation. Charity's Emergency Medicine Hospital Center, a Level I trauma center, consists of four units: the Major Emergency Department, the Accident Room, the Pediatric Emergency Room and the Emergency Obstetric Care Unit.

Coler Memorial Hospital, FDR Island, NY
New York City Health and Hospitals Corporation

Coler Memorial Hospital which opened in 1952 is now a 1,045-bed hospital. Coler not only provides skilled nursing beds, but also chronic care for skilled nursing residents as well as chronic medicine and long term rehabilitation services. A 29 bed children's unit provides service functions for multiply-handicapped and mentally retarded residents ages two to eighteen. Coler established one of the first long term care AIDS programs in the country with ten beds which will soon be expanded to fifty beds.

Coney Island Hospital, Brooklyn, NY
New York City Health and Hospitals Corporation

Coney Island Hospital was initially a first aid station which developed into a summer emergency hospital in 1902. The hospital, in 1908, was expanded into a permanent, year-round hospital. Currently, Coney Island Hospital is a 470-bed hospital that combines a particular concern in geriatric medicine with the latest services in diagnosis, treatment, and rehabilitation for all age groups. Major programs concern psychiatric services for adults, the aged and for children; outpatient dialysis; outpatient methadone maintenance; drug abuse programs and special programs for the many elderly residents of the Coney Island area. Also noteworthy is the Community Health Center which generates more than 20,000 annual visits.

E. A. Conway Memorial Hospital, Monroe, LA

E. A. Conway Memorial Hospital officially opened on July 1, 1941. A new five-story facility was opened on May 23, 1987. It is one of eight state-operated charity hospitals administered by the Office of Hospitals of the Department of Health and Hospitals. The new facility is licensed for operation of 252-beds, 197 of which are used, and is an acute care teaching facility, which serves a 12-parish area of Louisiana.

Earl K. Long Memorial Hospital, Baton Rouge, LA

The Louisiana Legislature authorized the establishment of a Charity Hospital in Baton Rouge in 1884 but it was not until 1968 that the hospital was constructed and renamed the Earl K. Long Memorial Hospital. With 211 beds, the hospital provides medical care to the city of Baton Rouge and seven parishes in the surrounding area. The hospital operates a very busy emergency department and several years ago it opened, and continues to operate during peak hours, a walk-in clinic for minor emergencies. The hospital is especially proud of the 13-bed Neonatal Intensive Care Unit which continues to operate at full capacity. In an attempt to provide preventive and follow-up care, it has developed a large ambulatory care program.

Erie County Medical Center, Buffalo, NY

Erie County Medical Center is a 534-bed tertiary hospital which offers a full range of therapeutic and diagnostic services and serves as the Level I trauma center for the Western New York region. Established as City Hospital in 1918, it evolved into Erie County Medical Center in 1978. The Medical Center has a wide range of services and aspects which are unique in Western New York. The Medical Center has the only emergency psychiatric service available on a 24-hour, seven-day-a-week basis with an 116-bed inpatient facility. ECMC also has units for inpatient detoxification for substance abuse patients, alcoholic detoxification, and alcoholic rehabilitation with three satellite facilities throughout Erie County. Also at ECMC are a spinal cord injury unit and a head trauma unit. They are designated as a center for trauma, burn and AIDS for Western New York with facilities for air ambulance patient transport. The Medical Center operates a school for handicapped children, and the only hospital-based adult muscular dystrophy clinic in Western New York.

Elmhurst Hospital, Elmhurst, NY
New York City Health and Hospitals Corporation

Called the old City Hospital on Welfare Island when established in 1832, the City Hospital Center at Elmhurst was transformed after its move to Elmhurst in 1957. The 659-bed hospital center has developed programs in geriatrics, dialysis, and substance abuse. Its Speech and Hearing Unit and Child Psychiatric Division are major medical resources in the community. Designated as a Level I trauma center, the emergency department is the most comprehensive emergency care facility and the major receiving psychiatric unit in Queens. It has also been designated as a comprehensive psychiatric emergency program site. Also of note are their Hispanic Outreach and Asian Mental Health Programs that provide culturally sensitive mental health programs in the hospital's catchment area.

Erlanger Medical Center, Chattanooga, TN

Erlanger Medical Center was established in Chattanooga in 1891. Erlanger is a 600-bed tertiary care hospital. The medical center's emergency care includes a Level I trauma center, a burn center, and an air

ambulance. One of the country's five craniofacial programs is located at Erlanger. The hospital is also host to the Miller Eye Center and the T.C. Thompson Children's Hospital. Special care for women and children is provided through Erlanger's high risk obstetrics program and their Level III neonatal intensive care unit. The Perinatal Center has three perinatologists on staff who provide high risk obstetrics care for the region.

Fairmont Hospital, San Leandro, CA

Alameda County Health Care System's 294-bed Fairmont Hospital provides a broad range of acute and sub-acute care services, including rehabilitation, neuro-respiratory, and a palliative care unit for AIDS and cancer patients. The Ambulatory Care program includes urgent care, medical clinic, primary care for children and adults, a variety of specialty clinics, and a mobile health van that provides screening and health care to seniors and the homeless. Fairmont has occupied its present site since 1864. In 1956, Fairmont became the first county hospital west of the Mississippi to develop a rehabilitation program. A 123-bed hospital-based skilled nursing facility was created in 1975. In 1986, a 9-bed AIDS unit was opened, and in 1988, 10 skilled nursing beds were dedicated for AIDS patients. Also in 1988, a 6-bed Alzheimer respite unit was opened. A 29-bed skilled nursing unit has evolved into a palliative care/oncology unit, which is well respected in the community.

Goldwater Memorial Hospital, FDR Island, NY
New York City Health and Hospitals Corporation

In 1939, Goldwater Memorial Hospital opened as the first special hospital for chronic diseases owned and operated by a municipality in this country. Goldwater specializes in long-term rehabilitation as differentiated from long-term custodial care. Their 944 beds are divided into three areas: skilled nursing, rehabilitation, and chronic medicine. Major components of the medical service include the Decubitus Ulcer Unit, Special Care Unit, Pulmonary Care Unit, Respiratory Therapy and AIDS Care Units. Unique to the Northeastern United States is Goldwater's Respirator Rehabilitation Service located within the Department of Rehabilitation Medicine.

Gouverneur Hospital, New York, NY
New York City Health and Hospitals Corporation

Gouverneur is a municipal hospital on the Lower East Side of Manhattan that was opened in 1885 to serve the many immigrants living in the area. Gouverneur's facilities include a 210-bed skilled nursing facility, a diagnostic and treatment center as well as a certified home health agency. Targeted services have been developed to meet the needs of the Hispanic and Asian communities, as is exemplified by two bicultural mental health programs. Services targeted for adolescents are provided in the comprehensive Adolescent Clinic. An on-site AIDS assessment center has been constructed to provide special outpatient treatment. Gouverneur also has a satellite clinic that provides a variety of outpatient services.

Grady Memorial Hospital, Atlanta, GA

Since 1892, Grady Memorial Hospital has served as family doctor and hospital for economically disadvantaged residents in Fulton and DeKalb Counties. It also treats victims of emergencies and serves as the primary hospital for handling major disasters. This 1,024-bed tertiary care facility is the largest hospital in the state of Georgia. A very important component of Grady's emergency care is its Emergency Medical Transport Service, which receives more than 62,000 requests annually. The facility operates the area's only hospital-based ambulance service and also has a perinatal unit that transports high-risk premature babies to Grady and to hospitals throughout Georgia. Among Grady's specialized programs are the largest public diabetes clinic in the country, a neonatal intensive care nursery, a rape crisis center, the Georgia Sickle Cell Center, the Georgia Poison Control Center and a regional burn center.

Harbor-UCLA Medical Center, Torrance, CA
Los Angeles County Department of Health Services

Harbor/UCLA Medical Center began as the station hospital for the Los Angeles Port of Embarkation. Later, the county acquired the facility, and in 1951 affiliated the hospital with the School of Medicine at the University of California, Los Angeles. A new eight-story replacement facility opened in 1963. Recent construction at the 553-bed hospital includes a medical library, a diagnostic imaging center for magnetic resonance imaging and CAT scans, as well as a child life addition to the main building. The hospital functions as the facility of last resort, delivering comprehensive health care services to the area's uninsured and underinsured. Through its research and clinical expertise, Harbor has achieved an international reputation. Its pediatric program, which includes neonatology and tertiary pediatrics, is the third ranked pediatric program in the United States. Other areas of excellence include obstetrics and gynecology, trauma care, and a kidney transplant program.

Harborview Medical Center, Seattle, WA

A county-owned medical center—affiliated with and managed by the University of Washington—Harborview has cared for the citizens of King County for over a century. Harborview, a 330-bed facility, offers services to patients throughout the Pacific Northwest. It serves as a major regional referral center for trauma, burns, seizure control, cardiac arrhythmia, and spinal cord and head injuries. Harborview is widely recognized for research in sexually transmitted

diseases, cholesterol and heart disease, AIDS, burn care, psychiatry, and other areas. Many of Harborview's programs are prototypes for services at other facilities around the world. The Medic I training program and the Sexual Assault Center are examples of programs which have received international recognition. Two satellite clinics complement Harborview's mission to care for those with limited or no resources.

Harlem Hospital Center, New York City, NY
New York City Health and Hospitals Corporation

Harlem Hospital began in 1887 as an emergency unit of Bellevue Hospital, serving patients waiting to be transferred to Wards and Randall Island facilities. The 642-bed hospital moved to its current site in 1907, and serves one of the poorest and medically underserved communities in the nation. Harlem Hospital has developed several innovative programs to meet the more critical health needs of the community. These include "The Heart of Harlem" cardiovascular disease risk screening program that raises awareness of risk behavior and teaches risk reduction skills. They also coordinate more than 25 funded AIDS grants that focus on service rather than research. Harlem Hospital has the only fully organized pediatric trauma service in New York City. Other services include a Level I trauma center, a primary care network, a hemodialysis unit, a rehabilitation medicine department, a speech and hearing center, and an ophthalmology department.

High Desert Hospital, Lancaster, CA
Los Angeles County Department of Health Services

High Desert Hospital, a 173-bed general acute care facility, is the only public hospital serving the 2,500 square mile North Los Angeles County area. High Desert Hospital provides acute medical/surgical services, skilled nursing services and acute medical rehabilitation services. The hospital does not have an emergency department, but offers an extended-hours outpatient clinic. High Desert Hospital has a unique partnership with Antelope Valley Hospital Medical Center to provide comprehensive obstetrical services to low income and indigent women in the Antelope Valley. High Desert Hospital provides prenatal and post-partum clinics, and deliveries are performed at Antelope Valley Hospital Medical Center by High Desert Hospital's staff or contract physicians. High Desert Hospital's master plan, which calls for replacement of the current hospital, and construction of a freestanding perinatal center, has been approved. The perinatal center will have the capacity for an estimated 2,600 births per year, and will also be designed to accommodate both high risk and low risk births.

Hilo Hospital, Hilo, HI

Hilo Hospital, currently owned and operated by the State of Hawaii, Department of Health, Community Hospitals Division, was originally built in 1897 and housed only seven beds. Today, the hospital is comprised of a 166-bed acute care facility housed in an ultra-modern building constructed in 1985, and a 108-bed long term care facility constructed in 1961. Hilo serves as the primary acute and emergency treatment and referral center on the island of Hawaii. While major trauma and tertiary care services are provided elsewhere, the hospital operates a home health service program, hemodialysis services, hospice care, a residential substance abuse program, and health education programs.

Hurley Medical Center, Flint, MI

543-bed Hurley Medical Center is the largest and most specialized hospital in a three-county Mid-Michigan area. An acute care facility, it is a regional referral center and a major provider of medical education programs. Since it opened in 1908 as Flint's first modern hospital, Hurley has been dedicated to providing quality health care for all, regardless of ability to pay. In 1979, a nine-story patient care tower was opened. Hurley is a tertiary center for many areas of expertise, including specialized care for women with high-risk pregnancies, neonatal and pediatric intensive care units, burn treatment, dialysis and kidney transplants, and a neurovigil unit for treatment of patients with serious head and spinal cord injuries or illnesses. Hurley is especially well-known for its comprehensive oncology, pediatric, emergency/trauma care and psychiatric services. Community outreach programs include operating a student health center, and adolescent health center at a local high school, a school/business partnership with a local elementary school and senior outreach centers at several locations.

Kauai Veterans Memorial Hospital, Waimea, HI

Kauai Veterans Memorial Hospital is located in Waimea, on the "Garden Island" of Kauai. The 44-bed hospital is the western-most, acute care, general hospital in the United States. As a member of Hawaii's twelve-hospital system, it cares for medical/surgical, intensive care, coronary care, obstetrics, and long-term care patients. Its mission is to provide for the medical needs of the west side population which currently has four sugar cane plantations and a large military facility as major employers, and for the tourist population's need of emergency care.

Kern Medical Center, Bakersfield, CA

The Kern County Hospital was first established for the people of Havilsh in 1867, one year after the founding of the county. In 1874, when the county seat was moved to Bakersfield, the hospital was also moved. On May 1, 1975, Kern Medical Center became the official name of the present medical complex, which is now licensed for 243 beds. Kern Medical Center has developed quality services, particularly in trauma, surgical and maternal and child care. These

services have attracted a variety of patients both paying and those that are indigent and dependent upon the county to provide medical care.

Kings County Hospital Center, Brooklyn, NY
New York City Health and Hospitals Corporation

Kings County Hospital Center has been a leader in health care for over 160 years. The 1,200-bed hospital performed the first open-heart surgery in New York State. Hospital medical staff demonstrated that yellow fever was spread by a mosquito, which led to the eradication of the disease. X-ray techniques developed at Kings County Hospital became standard in the field. Today Kings County's Trauma Center employs a special medical team to treat those patients with serious and/or multiple injuries, and is host to a burn unit. The Renal Dialysis Unit pioneered in the treatment of kidney disease and is one of the leaders in the field. The Psychiatric Department includes a learning center for children with mental retardation and developmental disabilities; a court-referred project for mental health treatment of adolescents, and an addictive disease service. The Ambulatory Care Department, among the largest in the city, hosts 130 clinics.

LAC*University of Southern California Medical Center, Los Angeles, CA
Los Angeles County Department of Health Services

With 2,045 beds, the LAC*USC Medical Center is one of the largest medical teaching hospitals in the country. The Medical Center has evolved from a single wood structure build in 1878, to a comprehensive medical complex with over fifty permanent and temporary buildings. General Hospital's Emergency Room, a Level I trauma center, has been rated as among the top 10 in Los Angeles. They operate one of only three burn centers in Los Angeles County. LAC*USC also hosts a psychiatric hospital, a women's hospital, and a pediatric pavilion which houses a communicable disease service with a separate clinic and emergency department. The medical center's highly specialized clinical, diagnostic and monitoring technology includes a laboratory and pathology section chemistry unit, an upgraded computerized tomography and ultrasound service, and a magnetic resonance imaging center. With the assistance of advanced computerized monitoring equipment, heart catheterization, pacemaker implantation and other electro-physiological procedures are performed.

Lincoln Medical & Mental Health Center, Bronx, NY
New York City Health and Hospitals Corporation

Lincoln Medical and Mental Health Center opened in 1839 to provide shelter for the elderly. A hospital was added in 1844. The 554-bed facility responds to community needs in the South Bronx by operating 133 clinics and by developing programs that break down barriers between patients and their hospital. Other services include a Level I trauma center and emergency department, an ambulatory surgery program, women's health initiative, a homeless services shelter, and a psychiatric adolescent day treatment program. The Substance Abuse Division is a drug-free program that uses only acupuncture and natural herbal remedies to treat drug addiction and alcoholism as well as such ailments as asthma and arthritis.

Louisiana State University Hospital, Shreveport, LA

As part of the statewide Louisiana State University Medical Center, the University Hospital in Shreveport fulfills the unique role of a university teaching hospital for public higher education in Louisiana. Serving Louisiana residents since its creation in 1876, University Hospital has a proud heritage of providing excellent medical care for the indigent. Today, the 457-bed facility is one of the nation's busiest university teaching hospitals, and provides a focus for the patient care, educational and research missions of the academic health center. In addition to caring for patients from North Louisiana, it provides referral care for many highly specialized services, such as burn and neonatal intensive care, to all Louisiana residents. Because of the research-oriented faculty who form the hospital's medical staff, patients have available to them the most current therapies as well as the opportunity to participate in many research protocols.

Memorial Hospital, Hollywood, FL

Memorial Hospital is a 737-bed public, community, not-for-profit hospital operated by the South Broward Hospital District. It opened in 1953 with 100 beds. Memorial Hospital consists of five hospitals under one roof: a community hospital, a psychiatric hospital, a regional referral hospital, a rehabilitation hospital, and a children's hospital. The Memorial Hospital Children's Center provides the most comprehensive level of pediatric subspecialists in Broward and Palm Beach Counties. Centers operated by Memorial Hospital include a 24-hour walk-in medical center, a same-day surgery center, a radiotherapy center, and an oncology center which hosts Memorial's children's cancer program.

Merrithew Memorial Hospital, Contra Costa County, CA

Merrithew Memorial Hospital is a 179-bed hospital that began providing services in the late 1800s. A general medical/surgical teaching facility, Merrithew operates under the direction of the Contra Costa County Board of Supervisors. The hospital operates five ambulatory care clinics offering family practice-oriented primary care as well as specialty clinics. Hospital and clinic physicians coordinate the continuity of care needed between outpatient and inpatient services. Health care services at Merrithew include: emergency care, prenatal care and obstetrics,

rehabilitation, psychiatry, geriatric services, hospice care, ambulatory care surgery, critical care, urgent care, and a health maintenance organization. Also available is the Senior Diner's Program that serves highly nutritious and appetizing meals on weekend evenings at low cost to those aged 60 and over.

Metropolitan Hospital Center, New York, NY
New York City Health and Hospitals Corporation

Founded in 1873, Metropolitan Hospital Center-originally located on Wards Island-was one of the first public hospitals in the country. The 608-bed facility is located on First Avenue. Health care services at Metropolitan include an emergency services department with a fully-equipped operating room; a renal dialysis unit; a special care unit; and an adolescent health center. Other programs include the Metropolitan Health Plan/HMO, the first municipal hospital-based HMO and the Mental Health Center, which provides acute and ambulatory care services including an adolescent clinic and a therapeutic nursery for preschoolers.

Milwaukee County Medical Complex, Milwaukee, WI

Founded in 1852, the Milwaukee County Medical Complex (MCMC) has evolved from a county hospital into a 345-bed major referral center for medical specialties, offering comprehensive inpatient, outpatient and emergency care with advanced diagnostic and rehabilitation services. MCMC's Trauma Center is the only Level I trauma center in Wisconsin. It is also the base for Milwaukee County Paramedic Communications and Training, and for Wisconsin's first helicopter ambulance. The Oncology and Radiation Oncology Departments are leading centers for diagnosis, treatment and research of all cancers including a nationally recognized bone marrow transplant program; and a state-of-the-art radiology department offers complete imaging options including Wisconsin's first magnetic resonance center. The Cardiology Department includes cardiac catheterization and modern diagnostic and monitoring capabilities. The Eye Institute at MCMC is one of 13 regional eye centers. The Neonatal Intensive Care Unit is a major referral center for high-risk pregnancies and babies with medical complications.

Nassau County Medical Center, East Meadow, NY

Since 1935, Nassau County Medical Center (NCMC) has provided the finest in health care to county residents, striving to combine superb medical care with a concern for the dignity of its patients and their families. NCMC includes a 615-bed tertiary care teaching hospital and a 900-bed geriatric center, and is affiliated with the State University of New York at Stony Brook. NCMC's centers of excellence include a completely self-contained burn center, a neonatal intensive care unit, Long Island's only breast imaging center, a child development center, a highly sophisticated microsurgery program, and a kidney dialysis center. In addition, the medical center has a comprehensive physical medicine and rehabilitation center, the most comprehensive intensive care capability in the region, an 18-bed respiratory care unit and magnetic resonance capability. Each year, more than 1,000 patients are transferred to the medical center from hospitals throughout the region.

Neponsit Health Care Center, New York, NY
New York City Health and Hospitals Corporation

The 284-bed geriatric institution now known as Neponsit Health Care Center, opened in 1961 as the Neponsit Home for the Aged. In the earlier 1900s Neponsit had been, among other things, a Naval hospital and tubercular children's hospital. Residents enjoy ocean view solariums on every floor, a well stocked library, music and game rooms, and a food and nutrition department experienced in preparing ethnic dishes catering to all cultural tastes. Neponsit also operates an adult day care services program and Telelink, a personal emergency response system operated 24 hours a day via the telephone.

North Central Bronx Hospital, Bronx, NY
New York City Health and Hospitals Corporation

North Central Bronx Hospital is a 373-bed acute care hospital whose emergency department provides first rate emergency services, expanded psychiatric services, and a community support program for victims of sexual assault. Its mission of "reaching out to the needs of the community" is met through several programs. The Midwifery Program, under the Department of Obstetrics and Gynecology, has received national and international recognition. Certified nurse-midwives perform 85% of the deliveries and support a strong bonding program for mother and infant. The Adolescent Pregnancy Program helps young mothers and their families through difficult prenatal and postnatal periods, providing counselling and continued education opportunities.

Northwest Texas Hospital, Amarillo, TX

384-bed Northwest Texas Hospital serves the largest clientele of any health care system in the upper half of Texas. Operating under Northwest Texas Hospital management are the Pavilion, the Center for Community Health, and Turning Point, an alcoholism and chemical dependency treatment center. Services available at Northwest are: the Amarillo Emergency Receiving Center, the area's only 24-hour Level II trauma center; a neonatal intensive care unit; a family birthing center; an after-hours pediatric outpatient care center; mental health services; and a sleep disorder center.

Olive View Medical Center, Sylmar, CA
Los Angeles County Department of Health Services

Olive View Medical Center provides a broad range of acute short term inpatient and outpatient services

to the residents of the San Fernando and Santa Clarita Valley areas of Los Angeles County. The original hospital was opened in 1920 as a center devoted to the treatment of tuberculosis. In 1971, a severe earthquake caused major damage to the buildings. The current 377-bed hospital building opened on May 9, 1987. Services offered at the medical center include medicine, surgery, dental, pediatrics, and obstetrics specialties and subspecialties; plus a basic medical and psychiatric emergency service. Community outreach is an important aspect of the services provided by Olive View. The medical center maintains a close referral network with the several public health centers throughout the San Fernando/Santa Clarita Valleys.

Parkland Memorial Hospital, Dallas, TX

Established in 1894 as the charity hospital for Dallas, Parkland became a teaching hospital in 1943. As a 940-bed public teaching hospital, Parkland has been a leader in many specialized aspects of trauma care, including burn treatment and rehabilitation, orthopedic trauma, trauma intensive care, and pediatric trauma. Although Parkland delivers a huge amount of its charges (73%) in uncompensated care, it also attracts paying patients. Parkland provides a wide range of specialized medical care in areas such as cardiology, kidney disorders, diagnostic radiology, severe skin disease, and neurological disorders. It is one of the nation's busiest maternity hospitals. The hospital helped pioneer the concept of high-risk maternity care. Parkland offers a number of other important community services, including a young adult clinic, the North Central Texas Poison Center, a rape crisis intervention center, a clinic for AIDS patients, and special programs for elderly patients and the homeless.

Phoebe Putney Memorial Hospital, Albany, GA

Phoebe Putney Memorial Hospital is a 399-bed, hospital authority-governed, facility that has been in operation for more than 75 years. Because of a continually high census in most areas of the hospital, Phoebe is presently involved in a multi-million dollar expansion project that will upgrade its bed capacity to 450. Phoebe not only serves as a major tertiary care facility, but also serves as the anchor of the Heart of the South Cardiac network. Over the past five years Albany and Phoebe have truly become the hub for health care in southwest Georgia. Phoebe has adopted the slogan "The Hospital with a Heart" and continues to pursue that goal.

Pontiac General Hospital, Pontiac, MI

At the turn of the century, a group of concerned Pontiac-area women recognized the need for a health care facility. In 1901, they formed the Pontiac Hospital Association (later known as the Oakland County Hospital Association) and began fund raising. On May 18, 1910, Oakland County Hospital opened its doors. In 1915, the Association gave the hospital, debt free, to the city of Pontiac. With its transfer of ownership, the hospital was renamed Pontiac City Hospital. Pontiac General has grown from 27 beds to its present capacity of 380, which includes 39 neonatal intensive care beds. Among the hospital's services are its Family Practice Program and two ambulatory care centers which provide services in radiation therapy, neonatal intensive care, and high risk obstetrics.

Queens Hospital Center, Jamaica, NY
New York City Health and Hospitals Corporation

The Queens Hospital Center (QHC), a 581-bed hospital, is the oldest municipal health care facility in the Borough of Queens, and provides a full range of general care, psychiatric, and substance abuse services. The hospital has special expertise in medical services for women and children. The center has 24-hour coverage by attending Obstetrics, state-of-the-art ultrasound and monitoring equipment and special services ranging from a prenatal substance abuse program to a teenage pregnancy program. Premature babies born at QHC are treated in the Neonatal Intensive Care Unit. QHC's emergency department meets the requirements of the New York Heart Association as a heart care station. A dedicated AIDS team provides medical, nursing, psychiatric and social services to a substantial number of AIDS inpatients and outpatients. The hospital provides a comprehensive range of mental health and substance abuse services. QHC is currently undertaking a major reconstruction project to build a new 525-bed hospital.

Rancho Los Amigos Medical Center, Downey, CA
Los Angeles County Department of Health Services

The 735-bed Rancho Los Amigos Medical Center is among the largest and most renowned rehabilitation centers in the world. In helping the severely handicapped person whose psychosocial problems were caused by accidents, disease, or birth defects, RLAMC's goal is to enable each patient to leave the hospital setting and pursue the most productive, rewarding life possible. Because RLAMC's programs are organized around the patient's problems, its organizational units include adult brain injury, spinal cord injury, and pediatric reconstruction surgery. They are one of the major rehabilitation centers in the country offering on-site rehabilitative surgical programs. Also available are ambulatory care services that specialize in medical and rehabilitative care to severely impaired outpatients and a 40-bed licensed skilled nursing facility for patients who have minimal rehabilitative potential but require extensive skilled nursing care.

Regional Medical Center at Memphis, Memphis, TN

Memphis Hospital was chartered in 1829 to provide care for the city's 700 inhabitants as well as for the

hundreds of sick travelers on the Mississippi River. The three-story brick hospital was eventually replaced, restructured and rechristened in 1983. Today's Regional Medical Center at Memphis, commonly known as THE MED, is housed in a new $60 million 443-bed hospital. In meeting the needs of the Mid-south, THE MED established four centers of excellence. The Level I trauma center, a combination emergency room-operating room-intensive care unit-blood bank-laboratory, is the only one of its kind in the Mid-South. The Burn Unit is staffed and equipped to handle the most severe burn cases. The High-Risk Obstetrics Unit is the regional referral unit for the treatment of high-risk pregnancies in the Mid-South. The 100-bed Newborn Center is one of the largest and oldest newborn intensive care facilities in the nation.

R.E. Thomason General Hospital, El Paso, TX

Thomason Hospital was founded by community physicians in 1914 as El Paso City-County Hospital, to provide care to those who could not otherwise afford medical care. Today, 355-bed Thomason serves as a major trauma center for the city. The Emergency Department is designated a Level I trauma center. Thomason serves as the base communication station for the citywide Emergency Medical Service System (911), and the County Poison Control Center. The hospital is a leader in maternal-infant services. Outpatient services include the Family Planning Services Department, parent and teenage counseling, the Outpatient Surgery Unit, and Sports Medicine/Rehabilitation Clinics. A large-scale renovation and a foot four-story addition were recently completed in 1989. The entire first level of the addition is devoted to the emergency/trauma center. The addition also enabled the expansion and consolidation of the maternal-infant services to include a newborn nursery, intensive care and intermediate nurseries, labor and delivery, and surgical delivery areas.

Riverside General Hospital, Riverside, CA

Riverside General Hospital-University Medical Center was founded in 1893 in a downtown Riverside hotel. The early "hospital" moved, three years later, to a two-story brick building in San Jacinto. After being demolished by an earthquake, the present hospital site was purchased and the new hospital was completed on Thanksgiving Day, 1900. Currently, the 358-bed hospital has the largest ambulatory care service in Riverside County with over 55 specialized clinics including medical, surgical, dental, dermatology, diabetic, ophthalmology, high-risk obstetrics, family planning and immunology. Its hemodialysis unit is one of the largest in the county, and its neonatal intensive care unit was the first in the area. The Emergency Department is designated a Level II trauma center. RGH-UMC has begun planning the construction and financing for a replacement teaching hospital to be located in Moreno Valley, a more central location, improving accessibility to the highest standard of medical care.

San Bernardino County Medical Center, San Bernardino, CA

San Bernardino County Medical Center traces its history back more than 125 years, to 1862, when the first County Hospital was begun. From patient care in converted private homes, the County Medical Center has evolved into a 293-bed teaching hospital on its present 40-acre campus in San Bernardino. With the only burn center serving the Inland Empire, the County Medical Center often treats patients from several hundred miles away. The hospital operates one of the two neonatal intensive care units in the county. The County Medical Center has been designated as a Level II trauma center for the county and, as such, receives trauma victims from a wide geographic area. In conjunction with Children's Hospital of Los Angeles, the County Medical Center operates a specialty clinic for children with leukemia, cystic fibrosis, and other unusual diseases. The County Medical Center also serves as a kidney transplant center for this area and has a chronic renal dialysis center.

San Joaquin General Hospital, French Camp, CA

As a modern acute care hospital, San Joaquin General Hospital aims to provide comprehensive, accessible health care to all residents of San Joaquin County; specialized health care programs not available elsewhere in the community; educational and training programs for physicians and other health care professionals; and effective business management of all hospital programs and activities. The 230-bed hospital also provides services which are regional in nature and often associated with large tertiary centers, such as: high risk perinatal services, newborn intensive care, pediatric surgery, physical medicine and rehabilitation, and trauma care.

Santa Clara Valley Medical Center, San Jose, CA

Founded in 1860, Santa Clara Valley Medical Center (SCVMC) is the oldest and only publicly-operated hospital serving the 1,400,000 residents of the county. With 791 licensed acute beds, SCVMC is the busiest medical center in the county as it provides comprehensive acute inpatient services as well as many renowned specialty care services including: a regional burn center, a rehabilitation center for traumatic spinal cord and head injury patients, a regional Level III neonatal intensive care unit, pediatric intensive care services, a regional poison information center, a regional high-risk pregnancy program, chronic renal dialysis services, and Life Flight-a helicopter transport program. SCVMC offers 70 primary, specialty, and subspecialty care clinics. SCVMC also operates three primary care satellite clinics located in the eastern,

central, and southern parts of the county. SCVMC's integrated system of clinics and acute inpatient care forms a continuum of comprehensive health care services, ensuring an appropriate and cost effective level of care.

Sea View Hospital & Home, Staten Island, NY
New York City Health and Hospitals Corporation

The 304-bed Sea View Hospital & Home originated in 1829 when it was called The Farm Colony and served as a poorhouse and later a home for both the poor and the insane. Early this century it became a haven for victims of tuberculosis, and today it serves the chronically ill and aged. In addition to its relatively stable patient population, Sea View offers a trend-setting adult day service, with a specialized Alzheimer's component, and a respite house. These provide community residents with access to medical clinics and a therapeutic activities program.

South Louisiana Medical Center, Houma, LA

South Louisiana Medical Center is a non-profit, 201 licensed bed (161-staffed), acute care teaching facility operated by the Louisiana State Department of Health and Hospitals. Established in 1978 as a health-care teaching facility, the Medical Center provides extensive inpatient, outpatient and emergency services to the residents of a five-parish area. Inpatient specialty services include general surgery, medicine, obstetrics-gynecology, ophthalmology, urology, orthopedics, pediatrics, critical care and newborn intensive care. The hospital also provides mental health care in a 15-bed nursing unit. The outpatient clinics offer care in dermatology, ear/nose/throat, gynecology, handicapped children, high risk obstetrics, medicine, oncology, ophthalmology, orthopedics, pediatrics, plastic surgery, pulmonary, surgery and urology.

St. Louis Regional Medical Center, St. Louis, MO

St. Louis Regional Medical Center was established in 1985 when both the City of St. Louis and adjacent St. Louis County agreed to close their own public hospitals and join in creating St. Louis Regional. The 304-bed hospital cares for a large number of high-risk obstetrical patients and has become one of the area's pre-eminent treatment centers for problem pregnancies and very sick newborns. It also has the lowest rate of Caesarean sections in the state of Missouri. Most of Regional's acute care admissions are through its emergency department, which has more visits annually than any other in the area. A new emergency department recently received public financing. Other services provided at the hospital are physical, occupational, and speech therapy; renal dialysis; and a number of outpatient specialty clinics.

St. Paul-Ramsey Medical Center, St. Paul, MN

The 427-bed St. Paul-Ramsey Medical Center began in 1869 as the city and county hospital. Known first as a leader in the treatment of contagious disease, it is now the region's designated trauma center, the state's poison control center and the largest burn treatment center in the Upper Midwest. Its emergency department is one of the most sophisticated in the Midwest and provides an operating room reserved for seriously injured patients, which is the only one of its kind in Minnesota. St. Paul-Ramsey provides more than 60 general and specialty outpatient clinics and a full spectrum of specialty hospital services. The medical center is the base for primary radio contact for all emergency medical transports in the Twin Cities' east metro area. The Medical Center also hosts a burn center and women's health services.

Tampa General Hospital, Tampa, FL

Since its inception in 1927, 971-bed Tampa General Hospital (TGH) has gained statewide recognition for excellence in medical care and has been considered a leader in cardiac care. TGH was officially recognized as one of America's ten most successful hospitals in 1989 by Healthcare Forum Journal, the only public hospital on the list. TGH has also been recognized for having the nation's most successful single aircraft helicopter program as well as for the implementation of a computerized managed care contract administration program. TGH also offers a full range of acute care services in addition to its Center of Distinction, which includes cardiovascular services, Level I trauma and burn care, maternal and child care, and rehabilitation. TGH also offers a comprehensive cancer treatment program and treatment for kidney disease.

Tarrant County Hospital District, John Peter Smith Hospital, Fort Worth, TX

Five acres of land were purchased by John Peter Smith in 1877 with a vision of a "...hospital where the indigent of Fort Worth and Tarrant County could have the best of medical care." In 1939 a 166-bed City-County Hospital was constructed on that land. Now, John Peter Smith Hospital is a 429-bed hospital which has been operated by Tarrant County Hospital District since 1959. The Hospital District is comprised of John Peter Smith Hospital, Trinity Springs Pavilion for Psychiatric Services, an outpatient services facility, and the Family Health Center, a training center for family practice residents. Community services include the Arlington Community Health Clinic, located in the second largest city in Tarrant County. Scheduled for completion on the campus in early 1991 is the Emergency Medical Services Building which will provide new facilities for emergency medicine, intensive care units and a new clinical laboratory.

Temple University Hospital, Philadelphia, PA

Founded in 1892 Temple University Hospital began as a 20-bed facility. The hospital has evolved into a 504-bed facility that is a university hospital, a referral hospital, and a community hospital. It hosts a Level I

trauma center and the hospital's ancillary services are located in three buildings that are equipped with state-of-the-art equipment. The hospital's Cardiac Medicine and Surgery Program performed the Delaware Valley's first heart transplant in April of 1984. The Cancer Program includes a newly developed comprehensive cancer center and an expanding bone marrow transplant program. In addition, the hospital has distinguished programs in diagnostic imaging, gastroenterology, kidney transplantation, neurosensory sciences, obstetrics/gynecology and orthopedics.

Truman Medical Center, Kansas City, MO

Kansas City, Missouri built its first public hospital in 1905; however, in the 1960s "Old General Hospital" was restructured and the 537-bed Truman Medical Center Corporation was established. A series of improvements culminated in 1976 in the dedication of a new complex on "Hospital Hill." On the hill are Children's Mercy Hospital, providing primary and tertiary pediatric care; Western Missouri Mental Health Center; Truman Medical Center, an adult full service hospital; and three University of Missouri at Kansas City graduate schools of health sciences. Truman Medical Center's two hospitals' specialty areas include a Level I trauma center, geriatrics and long term care, high risk obstetrics and neonatology, an internationally recognized eye care center for laser surgery, and research and significant efforts in stroke and hypertension treatment and research.

University Hospital Health Science Center at Syracuse, NY

University Hospital of the State University of New York Health Science Center at Syracuse is a Central New York tertiary care center that fulfills its role by meeting the needs of the most complex patient. The hospital provides its patients with specialized care through a unique teaching, research and patient care combination in an academic health science center. The 350-bed hospital serves as a regional referral center for burns, lithotripsy, AIDS, cancer treatment and research, pediatrics, renal dialysis, and rehabilitation services. Its eighty clinics provided more than 78,000 visits in 1989.

University Medical Center, Lafayette, Louisiana

In 1937, University Medical Center was established to serve the indigent population of Southwest Louisiana. The goals of the 188-bed hospital are : 1) to provide quality medical care for the people of Southwest Louisiana, giving priority when necessary to the indigent population, and 2) to participate in the education of various medical and paramedical personnel. There is a nursery designed to house 43 newborn infants, including 17 neonatal intensive care bassinets and 6 intermediate newborn care bassinets.

University of Medicine and Dentistry of New Jersey-University Hospital, Newark, NJ

The 518-bed University of Medicine and Dentistry of New Jersey-University Hospital represents the culmination of many years of city and state efforts to establish high caliber medical resources for health care and education. As a major health care resource in the poorest ward of New Jersey's largest city, it serves as the "family physician" to thousands of men, women and children with no other source of medical treatment. It provides a full range of general inpatient services and offers the widest array of outpatient programs in the state. Among the many unique resources and services at University Hospital are a Liver Institute, a trauma center, high-risk maternal and neonatal services, complex neurosurgery, the Center for Fertility and Reproductive Medicine, liver transplantation, and the New Jersey Cancer Center. The hospital has become the major provider of AIDS care in the city and its clinic dedicated to women with AIDS is believed to be the only one of its kind in the nation.

University of Nebraska Medical Center, Omaha, NE

The 310-bed University of Nebraska Medical Center is charged with providing the state with health science education, research and patient care. It is an internationally recognized tertiary care center and a major referral center, attracting a large volume of patients from around the U.S. and abroad. Its international reputation has stemmed from programs such as liver and bone marrow transplant services which are each in the top three most active programs in the nation. Also available at UNMC is a high risk obstetrics and neonatal intensive care unit, a geriatric center, a clinical cancer center, and the SkyMed emergency medical transport service.

University of Texas Health Center at Tyler, Tyler, TX

The University of Texas Health Center at Tyler is the state's primary referral center for cardiopulmonary disease. Acquired after World War II, the health center was initially a tuberculosis sanitorium and did not expand its scope of patient care beyond tuberculosis treatment until 1969. In 1971, the institution was renamed the East Texas Chest Hospital and charged with three major responsibilities: the care of patients suffering from all chest diseases; biomedical research; and education. After becoming part of the University of Texas System Board of Regents in 1977, the institution was renamed The University of Texas Health Center. Patients are referred from across the state to the 199-bed health center. To meet the needs of a rapidly growing population, the Health Center has established programs in cardiovascular services and surgery, cystic fibrosis diagnosis and treatment, occupational medicine, allergy and immunology, pulmonary rehabilitation and other specialty areas.

University of Texas Medical Branch Hospitals, Galveston, TX

John Sealy Hospital, with its 12-story, 856-bed tower and 22-room surgical suite, is the hub of the University of Texas Medical Branch (UTMB) Hospitals' patient care complex of 856 beds, seven hospitals and 85 outpatient clinics. Special care areas of the UTMB Hospitals include the Infant Special Care Unit, burn services with a human skin bank, the Cancer Center, kidney dialysis units, the Neurological Trauma Center and the Cardiothoracic Surgery Division. The Emergency Suite is a Level I trauma center with a helicopter ambulance. UTMB health maintenance and disease prevention efforts encompass numerous patient education programs available on an inpatient of outpatient basis. These include the Substance Abuse Program and a home health service.

Westchester County Medical Center, Valhalla, NY

In 1920, Westchester County opened Grasslands Hospital on the site that had already served for nearly a century as an almshouse and infirmary for the indigent. Currently, Westchester County Medical Center consists of four major components: the 500-bed acute care Medical Center Hospital; a 136-bed psychiatric institute; a 400-bed long term care facility; and a mental retardation institute. Subspecialties include a burn center, high risk obstetrics and neonatal intensive care center, cardiac care and a center for child and adolescent health. Kidney transplants have been performed since 1989. WCMC is the only hospital in the Hudson Valley to have been designated as a Level I trauma center. The hospital's helipad permits specialized teams to accompany or make possible specialized burn and trauma transport. The objective of the Center is to develop tertiary care programs that would be otherwise unavailable in the region. WCMC also has one of the highest occupancy rates in the region.

Wishard Memorial Hospital, Indianapolis, IN

For more than 130 years, Wishard Memorial Hospital has been the primary care provider for residents of Indianapolis' inner city. Since the 1880s, Wishard has provided ambulance service for the city, responding annually to over 52,224 calls for help. A sophisticated communications center, which opened in 1977, dispatches all Wishard units and coordinates emergency medical traffic in Marion County. The Center also coordinates the Indiana Hospital Emergency Radio Network which maintains daily contact with all hospitals in Marion and surrounding counties. Within the 460-bed hospital, Wishard provides an adult burn unit, an on-site geriatric clinic in a senior citizen housing complex, a cardiology institute, and a Level I trauma center. Wishard also provides access to 75 medical clinics primarily through its outpatient facility.

Woodhull Medical and Mental Health Center, Brooklyn, NY
New York City Health and Hospitals Corporation

Woodhull Medical and Mental Health Center opened in 1982. The 595-facility offers beds for adult intensive care, alcohol detoxification, internal medicine, obstetrics, gynecology, pediatrics, physical medicine, psychiatry, and surgery. WMMHC has established a broad-based approach to community-oriented health care. Their "Managed Care" concept is implemented through their Primary Care Enhancement System, which assigns a team of professionals to each individual. The Women's Health Initiative (WHI) is an enhancement of the Ob/Gyn Department. It provides health care and educational services to women of all ages, including educational services on HIV infection and prevention, prenatal care, counselling and family planning. Within WHI are the Teens 'N' Tots Program and an adolescent pregnancy program. A 19-bed drug detoxification unit is being planned and patterned after the Alcohol Detoxification Unit that is currently operational.

2

Key Characteristics of Safety Net Hospitals

Metropolitan area safety net hospitals play a critical role in our nation's health care system, serving as the family doctor for the poor, and providing their communities with numerous specialized services which are often too costly for other hospitals to provide. These hospitals, by the very nature of their mission and commitment, are extremely susceptible to financial problems; many of their patients are uninsured, and many of the services they provide are not fully reimbursed by third party payers. The Commission on Public General Hospitals, convened in the late 1970s concluded that, "urban public-general hospitals as a group have the most serious and persistent problems.[1]"

In this chapter, the characteristics that distinguish safety net hospitals from other short term hospitals will be outlined, using information from NAPH's member hospitals. NAPH represents more than 100 hospitals which serve as the health care safety net in their communities. The volume of care they provide, and their stated missions—dedicated to caring for all regardless of ability to pay—make these hospitals representative of the community of safety net hospitals nationally. NAPH's research of its members, the American Hospital Association's Annual Survey, and research from other groups provided the information in this chapter. Wherever possible, information is presented for several years, to illustrate changes occurring over time.

In addition, comparisons are made with other short term general hospitals, which further emphasizes the importance of the services provided by these facilities. The types of services provided, the volume of services, and the financing of these services illustrate the immense role these hospitals play in the American health care system.

Sources of Revenue

The scope and volume of services provided by public hospitals, as well as their safety net mission, are clearly reflected in their revenue structure. For 57 hospitals in 1988, total gross patient revenues (charges) totaled $10.3 billion, an average of $182.5 million per facility (See Table 2-1). Total gross patient revenues for these safety net hospitals far exceed the $29 million in gross patient revenues averaged by community hospitals in the U.S.[2]

Of total gross charges, the source of payment illustrates the types of patient population treated by these hospitals. Medicare represented nineteen percent (19%) of charges and Medicaid represented 30%; private insurance made up just 16%. Thirty-five percent of charges was for patients without any form of coverage (See Table 2-1, Figure 2-1). Examination of net operating revenues, the funds actually received by the hospital, illustrates the heavy reliance on state and local government to assist these hospitals in providing services (See Table 2-2, Figure 2-2). Overall, state and local funding (apart from Medicaid) provided 22% of the hospitals' net revenues. For some hospitals, this total is much higher. For example, Harris County Hospital District in Houston, Texas received $148.9 million, 72% of all net operating revenues from state and local sources. Jim Mongan, Executive Director of Truman Medical Center in Kansas City, Missouri states, "Almost half of our patients have no coverage under public or private programs. We live every day with the consequences of this country's failure to provide a national health program."[3] For NAPH hospitals, total net revenues averaged $147.2 million per hospital in 1988.

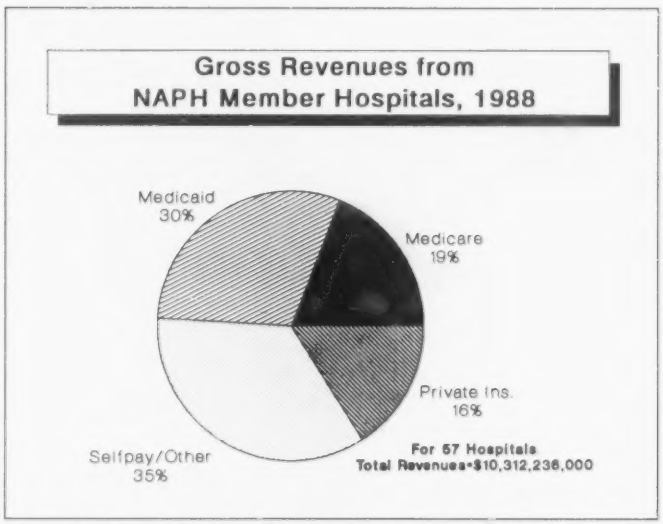


Figure 2-1 Gross Revenues from NAPH Member Hospitals

From 1987 to 1988, total net revenues increased 12%. Shifts in the relative proportions of the payer sources point to the increasing financial difficulties these hospitals are experiencing. Selfpay, including state and local government subsidies, which represented 30% of net revenues in 1987, increased to 33% in 1988 (See Table 2-3). However, private insurance, Medicaid, and Medicare all decreased.

Payer source proportions were not uniform across services. More than half (52%) of all outpatient visits in NAPH member hospitals were provided to unsponsored patients (See Figure 2-3). Selfpay/other represented 30% of all inpatient days. Medicare, Medicaid and private insurance each represented a smaller

Gross Revenues – 1988
(IN THOUSANDS)

Hospital	City	State	Medicare		Medicaid		Private		Selfpay/other		Total
Amarillo Hospital District	Amarillo	TX	20,690	27%	10,133	13%	32,172	42%	14,223	18%	77,218
Boston City Hospital	Boston	MA	28,050	17%	43,391	26%	19,561	12%	77,770	46%	168,772
Cook County Hospital	Chicago	IL	26,401	14%	86,696	47%	9,951	5%	62,737	34%	185,785
D.C. General	Washington	DC	22,575	16%	33,884	25%	10,855	8%	69,922	51%	137,237
Earl K. Long	Baton Rouge	LA	5,216	12%	12,359	29%			25,503	59%	43,078
Erlanger	Chattanooga	TN	55,917	30%	27,298	15%	77,226	42%	25,523	14%	185,964
Grady	Atlanta	GA	43,070	21%	37,252	18%	17,201	8%	108,115	53%	205,638
Harborview Medical Center	Seattle	WA	22,221	21%	45,303	42%	21,551	20%	17,983	17%	107,058
Harris County Hospital	Houston	TX	25,229	8%	27,335	9%	12,338	4%	252,985	80%	317,887
Health Sciences Center	Syracuse	NY	33,992	34%	18,601	18%	27,564	27%	21,246	21%	101,403
Hilo Hospital	Hilo	HI	8,343	26%	10,242	31%			14,028	43%	32,613
Hurley Medical Center	Flint	MI	38,552	23%	43,859	26%	33,787	20%	51,331	31%	167,530
Jackson Memorial	Miami	FL	60,568	11%	114,709	21%	89,321	17%	274,717	51%	539,315
Kula Hospital	Kula	HI	311	7%	3,924	85%	132	3%	224	5%	4,592
LAC–Harbor–UCLA	Torrance	CA	16,684	7%	96,281	40%	14,186	6%	113,849	47%	241,000
LAC–High Desert Hospital	Lancaster	CA	3,536	12%	13,301	44%	1,226	4%	12,131	40%	30,194
LAC–Martin Luther King/Drew	Los Angeles	CA	13,684	7%	76,001	38%	10,096	5%	100,444	50%	200,225
LAC–USC Medical Ctr.	Los Angeles	CA	24,797	4%	226,372	41%	12,968	2%	290,019	52%	554,156
Maricopa Medical Center	Phoenix	AZ	25,653	19%	49,757	38%	9,373	7%	46,781	36%	131,563
MD Anderson	Houston	TX	39,825	21%	2,644	1%	90,400	48%	54,289	29%	187,158
Medical Center of Central Georgia	Macon	GA	59,851	37%	21,029	13%	67,939	42%	12,941	8%	161,759
Memorial Hospital	Hollywood	FL	73,983	35%	9,762	5%	82,931	39%	45,522	21%	212,198
Memorial Medical Center	Savannah	GA	64,464	34%	31,125	16%	56,399	30%	38,488	20%	190,476
Merrithew Memorial Hospital	Martinez	CA	13,380	20%	27,323	41%	1,911	3%	23,254	35%	65,867
Milwaukee Medical Complex	Milwaukee	WI	43,478	27%	23,098	14%	42,705	27%	51,856	32%	161,136
NYC– Bellevue Hospital	NY	NY	34,916	12%	179,145	60%	16,958	6%	68,283	23%	299,302
NYC– Bronx Municipal	Bronx	NY	45,213	21%	117,157	54%	9,355	4%	46,305	21%	218,029
NYC– City Elmhurst	Queens	NY	33,642	20%	69,221	42%	13,596	8%	47,713	29%	164,172
NYC– Coney Island	Brooklyn	NY	53,521	38%	45,772	33%	11,876	9%	27,975	20%	139,145
NYC– Harlem Hospital	NY	NY	31,732	15%	106,776	50%	8,414	4%	66,722	31%	213,644
NYC– Kings County	Brooklyn	NY	24,646	8%	166,923	53%	22,075	7%	102,731	32%	316,374
NYC– Lincoln Medical	Bronx	NY	21,522	10%	119,873	58%	10,246	5%	55,030	27%	206,671
NYC– Metropolitan Hospital	NY	NY	27,880	16%	98,147	56%	9,091	5%	38,979	22%	174,096
NYC– North Central Bronx	Bronx	NY	19,919	16%	63,971	53%	9,387	8%	28,017	23%	121,294
NYC– Queens Hospital Center	Jamaica	NY	26,529	17%	78,795	50%	10,511	7%	39,701	26%	153,536
NYC– Woodhull Hospital	Brooklyn	NY	22,514	12%	117,628	62%	6,363	3%	42,326	22%	188,831
Parkland Memorial Hospital	Dallas	TX	46,970	16%	27,313	9%	42,889	15%	172,628	60%	289,800
Pontiac General Hospital	Pontiac	MI	31,809	33%	16,857	17%	46,807	48%	1,621	2%	97,095
Regional Medical Center	Memphis	TN	22,840	13%	43,528	24%	31,865	18%	81,188	45%	179,421
Riverside General Hospital	Riverside	CA	10,757	12%	27,348	31%	7,612	9%	43,699	49%	89,415
Samuel Mahelona Memorial	Kapaa	HI	225	5%	3,150	76%			796	19%	4,171
San Bernardino County	San Bernardino	CA	13,347	13%	31,414	30%	11,439	11%	46,975	46%	103,175
San Francisco General	San Francisco	CA	21,775	13%	42,553	26%	9,997	6%	91,952	55%	166,277
San Joaquin	Stockton	CA	11,792	16%	26,232	35%	10,463	14%	26,184	35%	74,671
San Mateo County General	San Mateo	CA	10,490	23%	11,015	24%	2,723	6%	21,669	47%	45,897
Santa Clara Valley	San Jose	CA	31,851	14%	88,315	40%	41,707	19%	57,985	26%	219,858
St. Lukes Roosevelt	New York	NY	135,210	32%	142,493	34%	70,505	17%	75,747	18%	423,955
Tampa General	Tampa	FL	94,925	31%	49,027	16%	109,171	35%	57,181	18%	310,304
Temple University	Philadelphia	PA	84,411	29%	102,857	35%	64,288	22%	40,234	14%	291,790
Truman Medical Center	Kansas City	MO	19,074	25%	12,408	16%	9,938	13%	34,054	45%	75,474
U of Chicago	Chicago	IL	98,824	24%	100,697	24%	163,251	40%	48,420	12%	411,192
U of New Mexico	Albuquerque	NM	16,371	12%	26,412	20%	37,577	28%	53,689	40%	134,049
UMDNJ	Newark	NJ	12,863	9%	29,426	21%	15,995	11%	85,146	59%	143,430
Univ of Cincinnati	Cincinnati	OH	47,580	26%	37,470	20%	15,336	8%	85,576	46%	186,063
University of Nebraska	Omaha	NE	23,060	20%	21,220	18%	51,326	44%	19,926	17%	115,533
UT Galveston	Galveston	TX	41,183	18%	26,203	12%	36,848	16%	121,348	54%	225,580
Wishard Memorial Hospital	Indianapolis	IN	26,472	22%	14,688	12%	13,545	11%	65,465	54%	120,170
Total			**1,914,432**	**19%**	**3,133,713**	**30%**	**1,862,942**	**18%**	**3,801,149**	**35%**	**10,312,236**
Average			**33,587**		**54,977**		**30,795**		**63,179**		**182,537**
Count			**57**		**57**		**54**		**57**		**57**
Minimum			**225**		**2,644**		**132**		**224**		**4,171**
Maximum			**135,210**		**226,372**		**163,251**		**290,019**		**554,156**

Note: Percents may not add to 100 due to rounding.

Table 2-1 Gross Revenues—1988

portion of outpatient care than of inpatient care. These numbers highlight a major flaw in our health care financing system-the lack of support for outpatient and ambulatory care.

Bad Debt and Charity Care

The extent of NAPH members' commitment to care for the uninsured is apparent in the proportion of bad debt and charity care provided by these hospitals. Although it would be ideal to separate bad debt (care provided to those who can pay but do not) from charity care (care provided to those from whom no payment is expected), most hospitals are unable to do this. In addition, the distinction between the two groups, those who "can" and "cannot" pay is often

Net Revenues – 1988
(IN THOUSANDS)

Hospital	City	State	Medicare	Medicaid	Private	Selfpay/ Other	City/ County/ State	Total Patient Revenues	Non– Patient Operating	Total Operating	Non– Operating	Total Revenue
Amarillo Hospital Dist.	Amarillo	TX	14,892	4,772	28,874	3,553	7,576	59,670	2,459	62,129	1,262	63,390
Boston City Hospital	Boston	MA	16,243	68,332	19,124	(6,798)	11,257	108,159	5,400	113,559		113,559
Cook County Hospital	Chicago	IL	23,098	64,753	9,218	1,000	189,445	287,512	2,850	290,362		290,362
D.C. General	Washington	DC	14,945	31,727	10,370	6,472	41,930	105,444	4,938	110,382		110,382
Earl K. Long	Baton Rouge	LA	1,125	2,736		14,395	14,803	33,060	97	33,156		33,156
Erlanger	Chattanooga	TN	40,362	19,820	72,751	4,862	3,000	140,394	3,338	143,733	5,271	148,004
Grady	Atlanta	GA	50,274	34,098	22,872	5,489	77,686	190,420	12,650	203,070	37	203,107
Harborview Medical Ctr.	Seattle	WA	21,535	39,016	21,551	4,705		86,808	13,088	99,893	4,116	104,009
Harris County Hospital	Houston	TX	9,335	10,117	12,338	21,444	148,859	202,093	4,505	206,598	3,424	210,022
Health Sciences Ctr.	Syracuse	NY	34,876	14,103	27,584	16,135	22,939	115,847	575	116,223		116,223
Hilo Hospital	Hilo	HI	6,022	7,707		12,982		26,711	682	27,393		27,393
Hurley Medical Center	Flint	MI	29,989	35,381	28,371	34,049		127,789	4,298	132,088	3,925	136,013
Jackson Memorial Hosp.	Miami	FL	41,867	72,253	82,313	13,539	110,920	320,922	14,507	335,429	17,329	352,758
Kula Hospital	Kula	HI	221	2,870	129	815	648	4,683	50	4,734	7	4,740
LAC–Harbor–UCLA	Torrance	CA	11,789	55,910	12,466	13,289	30,385	123,840	3,575	127,415	46,836	174,051
LAC–High Desert Hosp.	Lancaster	CA	2,191	7,572	876	1,122	2,086	13,847	2,333	16,180	65	16,245
LAC–M.L.King/Drew	Los Angeles	CA	9,481	41,347	8,730	18,990	26,412	101,960	8,960	110,920	59,472	170,392
LAC–USC Medical Ctr.	Los Angeles	CA	18,208	148,313	10,374	51,786	78,199	304,881	72,234	377,115	7,890	385,005
Maricopa Medical Ctr.	Phoenix	AZ	23,353	29,941	9,313	8,785	30,584	98,956	947	97,903	758	98,660
MD Anderson	Houston	TX	36,051	2,644	84,219	12,973	72,573	208,459	6,224	214,684		214,684
Med.Ctr. Central Georgia	Macon	GA	38,244	13,437	66,527	(5,380)	3,916	116,745	1,876	118,621	6,262	124,883
Memorial Hospital	Hollywood	FL	42,339	4,327	62,896	4,943	13,739	128,044	4,875	132,919	11,537	144,456
Memorial Medical Center	Savannah	GA	34,728	18,385	49,597	13,998	3,891	120,599	7,842	128,441	591	129,032
Merrithew Memorial Hosp.	Martinez	CA	9,786	19,651	1,029	7,186	25,911	63,563	1,465	65,028	718	65,746
Milwaukee Med. Complex	Milwaukee	WI	33,417	14,774	39,589	38,248		126,027	3,329	129,356		129,356
NYC– Bellevue Hospital	NY	NY	25,928	165,904	14,868	31,581	43,559	281,839	7,482	289,321		289,321
NYC– Bronx Municipal	Bronx	NY	41,211	89,649	6,118	28,814	20,884	186,677	2,930	189,607		189,607
NYC– City Elmhurst	Queens	NY	24,351	58,966	11,372	30,761	19,447	144,898	1,301	146,199		146,199
NYC– Coney Island	Brooklyn	NY	46,928	32,902	8,188	15,432	14,073	117,523	1,844	119,367		119,367
NYC– Harlem Hospital	NY	NY	34,510	80,635	8,224	18,059	28,030	169,459	3,040	172,500	79	172,578
NYC– Kings County	Brooklyn	NY	21,555	137,587	6,359	51,963	32,106	249,591	4,631	254,222		254,222
NYC– Lincoln Medical	Bronx	NY	16,871	101,444	8,516	7,555	24,650	159,137	2,820	161,957		161,957
NYC– Metropolitan Hosp.	NY	NY	19,096	74,734	2,249	39,382	10,869	146,330	2,263	148,593		148,593
NYC– N. Central Bronx	Bronx	NY	19,327	59,127	7,502	9,766	18,121	113,842	1,207	115,049		115,049
NYC– Queens Hosp.	Jamaica	NY	14,560	55,501	9,421	21,092	20,266	120,840	2,593	123,433		123,433
NYC– Woodhull Hosp.	Brooklyn	NY	19,427	116,388	5,177	5,251	18,173	164,415	1,590	166,005		166,005
Parkland Memorial Hosp.	Dallas	TX	30,852	17,941	32,187	2,567	111,124	194,851	2,389	197,040	5,686	202,726
Pontiac General Hosp.	Pontiac	MI	20,906	11,497	40,855	(6,031)	468	67,895	945	68,841	3,018	71,859
Regional Medical Center	Memphis	TN	15,189	46,360		40,461	26,801	128,791	2,262	131,053	464	131,517
Riverside General Hosp.	Riverside	CA	7,856	17,819	7,171	5,735	28,924	67,504	2,157	69,661		69,661
Samuel Mahelona Mem.	Kapaa	HI	219	1,655	(104)	779		2,550	104	2,653	941	3,595
San Bernardino County	San Bernardino	CA	8,275	17,388	8,949	9,684	21,730	66,026	2,123	68,149		68,149
San Francisco General	San Francisco	CA	22,042	24,700	5,017	21,895	24,305	97,759	993	98,752	89,097	187,850
San Joaquin	Stockton	CA	10,372	15,363	8,654	13,165	5,501	53,055	1,805	54,860	142	55,002
San Mateo County Gen.	San Mateo	CA	7,245	5,247	939	8,221	21,905	41,556	614	42,170	422	42,592
Santa Clara Valley	San Jose	CA	22,539	45,973	33,710	2,145	63,713	168,080	75,096	243,175		243,175
St. Lukes Roosevelt	New York	NY	106,912	117,731	58,025	51,452		336,120	47,033	383,153	5,630	388,783
Tampa General	Tampa	FL	57,983	27,055	95,635	3,588		184,261	4,067	188,328	7,756	196,084
Temple University	Philadelphia	PA	39,333	43,233	39,659	9,858		132,083	2,631	134,714	3,883	138,597
Truman Medical Center	Kansas City	MO	14,687	6,723	7,975	4,367	17,674	51,426	4,900	56,326	311	56,637
U of Chicago	Chicago	IL	55,507	31,438	136,579	10,414		233,938	3,914	237,852	4,507	242,359
U of New Mexico	Albuquerque	NM	13,161	13,799	35,536	7,466	15,612	85,573	4,465	90,038	1,613	91,651
UMDNJ	Newark	NJ	8,655	18,272	7,346	57,937		92,210	60,171	152,381		152,381
Univ of Cincinnati	Cincinnati	OH	49,552	34,780	15,871	53,645	23,178	177,006	12,879	189,885	8,681	198,566
University of Nebraska	Omaha	NE	17,623	13,103	46,919	12,581		90,227	16,716	106,943		106,943
UT Galveston	Galveston	TX	24,685	13,811	29,914	5,890	106,631	180,932	6,863	187,795		187,795
Wishard Memorial Hosp.	Indianapolis	IN	22,968	11,472	11,126	15,174	30,313	91,053	11,548	102,601	313	102,914
Total			**1,405,810**	**2,266,961**	**1,388,858**	**884,830**	**1,864,821**	**7,811,278**	**478,474**	**8,089,752**	**301,840**	**8,391,592**
Average			**24,663**	**39,771**	**25,720**	**15,523**	**38,192**	**133,531**	**8,394**	**141,927**	**9,147**	**147,221**
Count			**57**	**57**	**54**	**57**	**48**	**57**	**57**	**57**	**33**	**57**
Minimum			**219**	**1,655**	**(104)**	**(6,798)**	**468**	**2,550**	**50**	**2,653**	**7**	**3,595**
Maximum			**106,912**	**165,904**	**136,579**	**57,937**	**189,445**	**336,120**	**75,096**	**383,153**	**89,097**	**388,783**
Percent of Patient Revenues			**18%**	**30%**	**18%**	**12%**	**22%**					

Table 2-2 Net Revenues–1988

Table 2-3 Net Patient Revenues, 1987 and 1988

Net Patient Revenues, 1987 and 1988

(IN THOUSANDS)

			Medicare		Medicaid		Private Insurance		Selfpay/Other		Total	
			1987	1988	1987	1988	1987	1988	1987	1988	1987	1988
Boston City Hospital	Boston	MA	16,023	16,243	67,649	68,332	17,175	19,124	1,673	4,460	102,520	108,159
D.C. General	Washington	DC	14,860	14,945	27,308	31,727	6,100	10,370	46,703	48,402	94,971	105,444
Earl K. Long	Baton Rouge	LA	2,545	1,125	4,961	2,736	800	0	15,556	29,198	23,861	33,060
Grady	Atlanta	GA	26,284	50,274	30,685	34,098	12,784	22,872	91,653	83,177	161,406	190,420
Harborview Medical Center	Seattle	WA	21,058	21,535	33,096	39,016	13,646	21,551	12,840	4,705	80,640	86,808
Harris County Hospital	Houston	TX	19,095	9,335	17,247	10,117	14,314	12,338	153,622	170,303	204,277	202,093
Hurley Medical Center	Flint	MI	26,880	29,989	27,369	35,381	59,458	28,371	(1,197)	34,049	112,510	127,789
LAC–Harbor–UCLA	Torrance	CA	11,998	11,789	57,235	55,910	10,579	12,466	42,809	43,675	122,621	123,840
LAC–High Desert Hospital	Lancaster	CA	1,943	2,191	6,678	7,572	1,2[illegible]	876	2,874	3,208	12,714	13,847
LAC–Martin Luther King/Drew	Los Angeles	CA	9,700	8,481	37,566	41,347	5,287	6,730	15,987	25,402	68,540	81,960
Maricopa Medical Center	Phoenix	AZ	19,762	23,353	29,602	26,941	5,220	9,313	38,042	37,350	92,626	96,956
MD Anderson	Houston	TX	33,560	36,051	1,176	2,644	75,920	84,219	8,549	85,546	119,205	208,459
Merrithew Memorial Hospital	Martinez	CA	6,251	9,786	8,046	19,651	543	1,029	38,933	33,097	53,773	63,563
Milwaukee Medical Complex	Milwaukee	WI	30,088	33,417	13,208	14,774	44,588	39,589	28,293	38,246	116,177	126,027
NYC– Bellevue Hospital	NY	NY	14,110	25,928	126,024	165,904	13,521	14,868	37,717	75,140	191,373	281,839
NYC– Bronx Municipal	Bronx	NY	38,868	41,211	89,545	89,649	24,439	6,118	8,131	49,698	160,983	186,677
NYC– City Elmhurst	Queens	NY	24,163	24,351	52,392	58,966	10,341	11,372	55,035	50,208	141,931	144,898
NYC– Coney Island	Brooklyn	NY	39,533	46,928	37,877	32,902	7,970	8,188	39,569	29,505	124,949	117,523
NYC– Harlem Hospital	NY	NY	22,849	34,510	87,860	80,635	5,118	8,224	44,218	46,090	160,044	169,459
NYC– Kings County	Brooklyn	NY	21,855	21,555	106,355	137,587	9,890	6,359	122,860	84,090	260,959	249,591
NYC– Lincoln Medical	Bronx	NY	13,559	16,971	124,795	101,444	6,100	8,516	6,874	32,205	151,328	159,137
NYC– Metropolitan Hospital	NY	NY	18,516	19,096	81,677	74,734	4,759	2,249	4,060	50,252	109,012	146,330
NYC– Queens Hospital Center	Jamaica	NY	12,110	14,560	60,537	55,501	8,026	9,421	11,189	41,358	91,862	120,840
NYC– Woodhull Hospital	Brooklyn	NY	14,374	19,427	94,032	116,388	5,084	5,177	49,693	23,424	163,183	164,415
Parkland Memorial Hospital	Dallas	TX	24,663	30,852	11,006	17,941	36,088	32,167	99,559	113,691	171,317	194,651
Pontiac General Hospital	Pontiac	MI	17,907	20,906	8,790	11,497	35,213	40,855	2,084	(5,563)	63,994	67,695
Riverside General Hospital	Riverside	CA	7,682	7,856	19,682	17,819	3,600	7,171	26,450	34,659	57,414	67,504
San Bernardino County	San Bernardino	CA	9,873	8,275	15,856	17,388	5,747	8,949	27,294	31,414	58,770	66,026
Santa Clara Valley	San Jose	CA	28,572	22,539	47,696	45,973	21,639	33,710	12,642	2,145	110,550	104,367
St.Luke's Roosevelt	New York	NY	111,082	108,912	97,476	117,731	59,738	58,025	16,900	51,452	285,196	336,120
Tampa General	Tampa	FL	57,412	57,983	17,674	27,055	66,595	95,635	25,301	3,588	166,982	184,261
Truman Medical Center	Kansas City	MO	15,920	14,687	8,944	6,723	7,436	7,975	18,677	22,041	50,977	51,426
U of Chicago	Chicago	IL	51,225	55,507	33,183	31,438	109,506	136,579	3,998	10,414	197,912	233,938
U of New Mexico	Albuquerque	NM	11,286	13,161	12,841	13,799	26,458	35,536	20,505	23,077	71,090	85,573
UMDNJ	Newark	NJ	13,316	8,655	28,631	18,272	23,263	7,346	21,963	57,937	87,173	92,210
Univ of Cincinnati	Cincinnati	OH	51,011	49,552	42,841	34,760	13,661	15,871	65,091	76,823	172,604	177,006
University of Nebraska	Omaha	NE	13,466	17,623	10,123	13,103	35,853	46,919	12,098	12,581	71,541	90,227
UT Galveston	Galveston	TX	31,956	24,685	13,942	13,811	39,526	29,914	97,338	112,521	182,762	180,932
Wishard Memorial Hospital	Indianapolis	IN	19,480	22,968	11,291	11,472	9,156	11,126	65,363	45,4[illegible]	105,290	91,053
Total			**908,811**	**980,972**	**1,535,245**	**1,634,405**	**839,189**	**897,994**	**1,389,271**	**1,710,592**	**4,672,517**	**5,223,962**
Percent			**19.5%**	**18.8%**	**32.9%**	**31.3%**	**18.0%**	**17.2%**	**29.7%**	**32.7%**	**100.0%**	**100.0%**
Number of Hospitals			**38**									

blurry at best. For public hospitals, with large proportions of poor patients, it is unlikely that much of the care in this category is bad debt. Hospital accounting systems are far from uniform across the nation, as well, making comparison of bad debt and charity care figures difficult.

In 1988, NAPH hospitals reported an average of $76.9 million in bad debt/charity care and allowances—the difference between gross revenues (charges) and net revenues (See Table 2-4), representing 42% of charges. These hospitals reported state and local government subsidies averaged $36.2 million per hospital, leaving the average NAPH hospital with uncompensated care of $40.7 million. Total uncompensated care across the nation is difficult to measure; however, the AHA reports that uncompensated care in 1988 totaled approximately $8.3 billion nationally.[4] For the 57 NAPH hospitals reporting, uncompensated care, *after all subsidies are taken into account*, totaled more than $2.3 billion, representing a large share of the nation's total uncompensated care load.

There is consensus that the overall amount of unsponsored care is growing, and that the burden of unsponsored care is not distributed evenly across hospitals. The AHA reports that uncompensated care totalled $3 billion nationally in 1980. By 1987, the figure was $7.5 billion, and by 1988 had risen to $8.3 billion. Bad debt and charity care in NAPH hospitals, before subsidies are added, both in total dollars and as a percentage of total charges, have been increasing since NAPH began tracking this data in 1982 (See Figure 2-4). In 1982, NAPH hospitals averaged $23.4 million in bad debt and charity care, just over 20% of gross charges. By 1985, hospitals were averaging $48.6 million, or 32% of gross charges. Measured in total dollars, bad debt and charity care increased by 1988 to $76.9 million, representing 42% of gross charges.

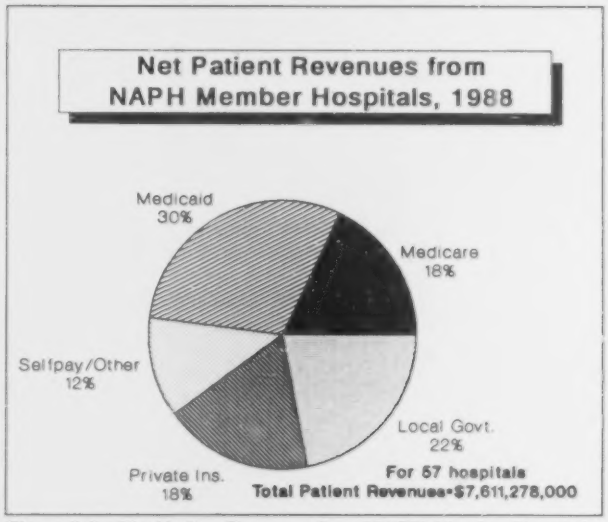


Figure 2-2 Net Patient Revenues from NAPH Member Hospitals

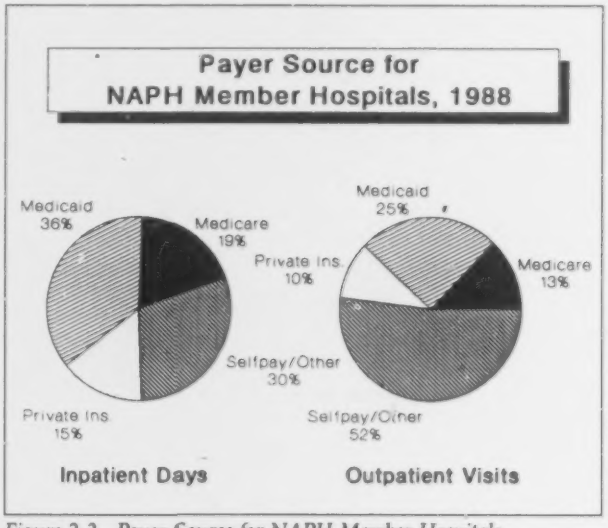


Figure 2-3 Payer Source for NAPH Member Hospitals

Hospital Operating Margins and Operating Expenses

The growth in the amount of uncompensated care provided by safety net hospitals has caused a financial strain on these facilities. NAPH hospitals averaged operating expenses of $151.3 million. Salaries represented almost half, benefits 11%, and supplies 26% (See Figure 2-5). Operating revenues, however, averaged $141.9 million per hospital, leaving an average operating margin of −$9.4 million per hospital in 1988 (See Table 2-5 and Figure 2-6). Fifty-seven NAPH hospitals lost a total of $534 million in providing patient care in that year. When this margin is expressed as a percentage of the expense budget, the size of these losses becomes clear. For the average NAPH hospital, the operating margin represented 6.2% of operating expenses. Without the subsidies provided by state and local tax dollars, the average public hospital would have a negative operating margin of greater than 30%.

The size of the negative operating margins have also been increasing over the past few years, and more hospitals have reported negative margins each year. In 1986, 50% of NAPH hospitals reported a negative operating margin. By 1988, 63% of all NAPH hospitals had a negative operating margin. In addition, negative operating margins have grown, both in absolute size and as a proportion of operating expenses. In 1986, NAPH hospitals averaged operating margins of −$6.6 million. In 1988, operating margins averaged −$9.4 million. In 1988, for those hospitals with a negative operating margin, their margin averaged −$19.6 million.

As negative operating margins continue to increase, hospitals face an increasing strain on their resources.

Bad Debt and Charity Care Allowances
Average in Thousands per NAPH Hospital – 1988

Source	Gross Revenues	Net Revenues	Bad Debt/ Charity Care/ Allowances
Medicare	33,587	24,663	8,924
Medicaid	54,977	39,771	15,206
Private Insurance	30,795	25,720	5,075
Selfpay/Other	63,178	15,523	47,655
Total	182,537	105,677	76,860
City/County Subsidies			36,192
Total Uncompensated Care			40,668

Table 2-4 Bad Debt and Charity Care Allowances

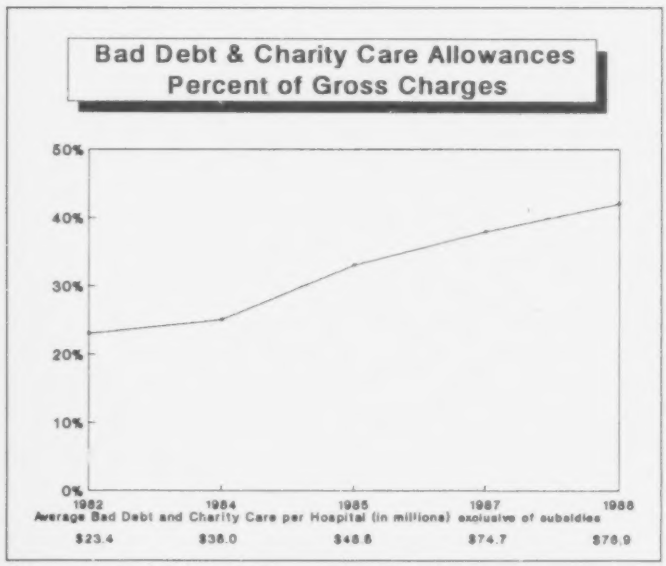


Figure 2-4 Bad Debt and Charity Care Allowances

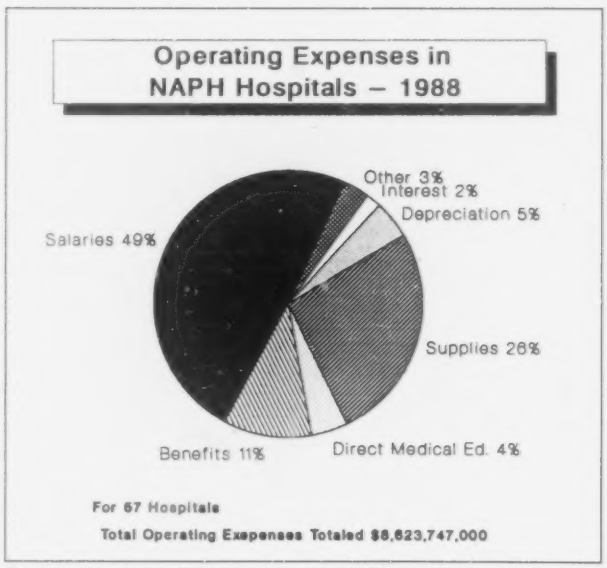


Figure 2-5 Operating Expenses in NAPH Hospitals

Hospitals with a negative margin must rely on non-operating revenues, may shift money from reserves or delay capital improvements to free up funds for patient care. The long-term consequences of delaying capital improvements do not enhance a hospital's financial viability. In fact, many NAPH hospitals are now facing the consequences of years of diverting money away from capital projects to fund patient care.

Service Volume

Another distinctive feature of safety net hospitals is the volume of services they provide. Utilization of services in a safety net hospital is far above that of the average acute care hospital, further evidence of the growth in the medically disenfranchised population and in their health care needs. The AIDS

Revenues and Expenses – 1988
(IN THOUSANDS)

Hospital	City	State	Operating Revenues	Total Revenues	Operating Expenses	Total Expenses
Amarillo Hospital District	Amarillo	TX	62,129	63,390	59,204	59,212
Boston City Hospital	Boston	MA	113,559	113,559	137,381	137,381
Cook County Hospital	Chicago	IL	290,362	290,362	288,816	288,816
D.C. General	Washington,	DC	110,382	110,382	111,440	111,440
Earl K. Long	Baton Rouge	LA	33,156	33,156	26,019	26,019
Erlanger	Chattanooga	TN	143,733	149,004	139,678	139,678
Grady	Atlanta	GA	203,070	203,107	203,218	203,218
Harborview Medical Center	Seattle	WA	99,893	104,009	103,950	106,353
Harris County Hospital	Houston	TX	206,598	210,022	194,231	194,231
Health Sciences Center	Syracuse	NY	116,223	116,223	116,223	116,223
Hilo Hospital	Hilo	HI	27,393	27,393	29,379	31,977
Hurley Medical Center	Flint	MI	132,088	136,013	104,992	104,992
Jackson Memorial Hospital	Miami	FL	335,429	352,758	352,270	352,270
Kula Hospital	Kula	HI	4,734	4,740	6,830	6,830
LAC–Harbor–UCLA	Torrance	CA	127,415	174,051	178,396	179,050
LAC–High Desert Hospital	Lancaster	CA	16,180	16,245	27,102	27,119
LAC–Martin Luther King/Drew	Los Angeles	CA	110,920	170,392	186,430	186,430
LAC–USC Medical Ctr.	Los Angeles	CA	377,115	385,005	456,509	466,503
Maricopa Medical Center	Pheonix	AZ	97,903	98,660	116,297	116,297
MD Anderson	Houston	TX	214,684	214,684	203,724	203,724
Medical Ctr. of Central Georgia	Macon	GA	118,621	124,883	111,736	111,736
Memorial Hospital	Hollywood	FL	132,919	144,456	128,196	130,699
Memorial Medical Center	Savannah	GA	128,515	129,106	127,165	127,165
Merrithew Memorial Hospital	Martinez	CA	65,028	65,746	64,823	64,823
Milwaukee Medical Complex	Milwaukee	WI	129,356	129,356	134,032	134,032
NYC– Bellevue Hospital	NY	NY	289,321	289,321	298,765	298,765
NYC– Bronx Municipal	Bronx	NY	189,607	189,607	215,491	215,491
NYC– City Elmhurst	Queens	NY	146,199	146,199	173,180	173,180
NYC– Coney Island	Brooklyn	NY	119,367	119,367	142,022	142,022
NYC– Harlem Hospital	NY	NY	172,500	172,578	230,172	230,172
NYC– Kings County	Brooklyn	NY	254,222	254,222	308,715	308,715
NYC– Lincoln Medical	Bronx	NY	161,957	161,957	193,028	193,028
NYC– Metropolitan Hosiptal	NY	NY	148,593	148,593	153,467	153,467
NYC– North Central Bronx	Bronx	NY	115,049	115,049	122,830	122,830
NYC– Queens Hospital Center	Jamaica	NY	123,433	123,433	152,127	152,127
NYC– Woodhull Hospital	Brooklyn	NY	166,005	166,005	174,441	174,441
Parkland Memorial Hospital	Dallas	TX	197,040	202,726	198,260	198,260
Pontiac General Hospital	Pontiac	MI	68,641	71,659	67,162	67,162
Regional Medical Center	Memphis	TN	131,053	131,517	129,449	129,449
Riverside General Hospital	Riverside	CA	69,661	69,661	68,008	68,008
Samuel Mahelona Memorial	Kapaa	HI	2,653	3,595	5,423	5,423
San Bernardino County	San Bernardino	CA	68,149	68,149	72,114	72,114
San Francisco General	San Francisco	CA	98,752	187,850	191,545	191,545
San Joaquin	Stockton	CA	54,860	55,002	54,687	54,807
San Mateo County General	San Mateo	CA	42,170	42,592	41,923	41,923
Santa Clara Valley	San Jose	CA	243,175	243,175	174,598	174,598
St.Luke's Roosevelt	New York	NY	383,153	388,783	383,362	392,547
Tampa General	Tampa	FL	188,328	196,084	192,854	192,854
Temple University	Philadelphia	PA	134,714	138,597	139,231	139,231
Truman Medical Center	Kansas City	MO	56,326	56,637	59,701	59,701
U of Chicago	Chicago	IL	237,852	242,359	232,258	232,733
U of New Mexico	Albuquerque	NM	90,038	91,651	82,608	82,608
UMDNJ	Newark	NJ	152,381	152,381	153,229	153,229
Univ of Cincinnati	Cincinnati	OH	189,885	198,566	189,099	189,099
University of Nebraska	Omaha	NE	106,943	106,943	102,858	102,858
UT Galveston	Galveston	TX	187,795	187,795	207,180	207,180
Wishard Memorial Hospital	Indianapolis	IN	102,601	102,914	105,921	105,921
Total			**8,089,826**	**8,391,666**	**8,623,747**	**8,651,703**
Average			**141,927**	**147,222**	**151,294**	**151,784**
Count			**57**	**57**	**57**	**57**
Minimum			**2,653**	**3,595**	**5,423**	**5,423**
Maximum			**383,153**	**388,783**	**456,509**	**466,503**

Table 2-5 Revenues and Expenses—1988

Utilization

Hospital	City	State	Licensed Beds	Staffed Beds	Admissions	Days	Births	Occup. Rate	ED Visits	Other Outpatient	Total Outpatient
Amarillo Hospital District	Amarillo	TX	250	273	13,298	69,899	2,990	70%	43,200	94,282	137,482
Boston City Hospital	Boston	MA		344	15,624	103,875	1,763	83%	85,144	134,749	199,893
Cook County Hospital	Chicago	IL	1,000	1,001	34,409	237,277	5,724	65%	252,237	397,588	649,825
D.C. General	Washington	DC	442	420	13,832	120,581	1,890	79%	85,032	109,467	194,499
Earl K. Long	Baton Rouge	LA		188	12,302	55,883	3,099	91%			
Erlanger	Chattanooga	TN	754	522	25,305	149,810	3,756	79%	84,731	41,286	136,017
Grady	Atlanta	GA	1,048	938	40,693	261,897	8,123	77%	261,067	593,088	854,155
Harborview Medical Center	Seattle	WA	413	330	11,252	101,426		84%	40,888	266,405	307,293
Harris County Hospital	Houston	TX	1,045	811	41,580	248,726	14,050	83%	99,122	489,744	586,866
Health Sciences Center	Syracuse	NY	350	350	10,849	101,588		80%	42,442	188,237	230,679
Hilo Hospital	Hilo	HI	274	274	7,272	79,071	1,214	79%	15,498	47,679	63,177
Hurley Medical Center	Flint	MI	543	540	19,134	127,781	3,059	65%	38,865	57,649	96,514
Kula Hospital	Kula	HI	105	101	118	34,002		92%	49	1,017	1,066
LAC–Harbor–UCLA	Torrance	CA	553	501	25,187	154,105	6,773	84%	83,048	209,185	292,233
LAC–High Desert Hospital	Lancaster	CA	173	135	1,612	36,954		75%		39,471	39,471
LAC–Martin Luther King/Drew	Los Angeles	CA		393	21,203	132,113	7,862	92%			
LAC–USC Medical Ctr.	Los Angeles	CA	2,045	1,454	73,410	483,342	15,490	91%	190,748	366,704	557,450
Maricopa Medical Center	Phoenix	AZ	555	524	20,564	139,814	5,551	73%	60,266	157,702	217,968
MD Anderson	Houston	TX	523	514	18,444	137,503		73%		283,823	283,823
Medical Center of Central Georgia	Macon	GA	518	501	19,777	134,798	2,745	74%	39,775	126,546	166,321
Memorial Hospital	Hollywood	FL	737	737	25,760	204,708	4,619	76%	79,202	2,758	81,960
Memorial Medical Center	Savannah	GA	475	488	18,206	144,134	2,440	81%	43,270	43,919	87,189
Merrithew Memorial Hospital	Martinez	CA	192	127	7,235	46,805	1,159	101%	24,435	163,572	188,007
Milwaukee Medical Complex	Milwaukee	WI	329	338	11,570	94,471	800	77%	39,847	175,729	215,676
Nassau County Medical Center	East Meadow	NY	615	615	17,410	176,560	2,882	79%	77,312	179,524	256,836
NYC– Bellevue Hospital	NY	NY	1,242	1,217	25,950	404,355	1,913	91%	92,100	325,766	417,866
NYC– Bronx Municipal	Bronx	NY		739	23,729	235,748	3,395	87%			
NYC– City Elmhurst	Queens	NY	628	618	19,749	230,148	3,007	102%	107,825	321,892	429,317
NYC– Coney Island	Brooklyn	NY		445	15,815	154,466	1,558	95%			
NYC– Harlem Hospital	NY	NY	676	676	21,631	225,519	2,475	91%	94,701	687,029	781,730
NYC– Kings County	Brooklyn	NY		1,204	35,573	372,223	5,118	85%			
NYC– Lincoln Medical	Bronx	NY		568	25,400	198,201	4,822	96%			
NYC– Metropolitan Hosiptal	NY	NY		589	16,458	199,585	2,127	96%			
NYC– North Central Bronx	Bronx	NY	343	343	13,711	111,833	2,986	89%	68,370	161,701	230,071
NYC– Queens Hospital Center	Jamaica	NY	581	455	15,803	168,965	2,576	102%	87,328	234,034	321,362
NYC– Woodhull Hospital	Brooklyn	NY		526	19,902	177,040	3,390	92%			
Parkland Memorial Hospital	Dallas	TX	940	862	38,817	250,189	14,543	80%	137,179	373,178	510,357
Pontiac General Hospital	Pontiac	MI	380	298	10,655	67,834	1,734	62%	21,580	105,876	127,456
Regional Medical Center	Memphis	TN	620	437	22,456	142,254	7,545	89%	86,436	98,896	185,332
Riverside General Hospital	Riverside	CA	358	312	14,867	86,634	2,804	76%	51,314	110,397	161,711
Samuel Mahelona Memorial	Kapaa	HI	84	84	254	26,033		85%		833	833
San Bernardino County	San Bernardino	CA	230	230	10,127	58,309	2,029	69%	30,235	94,875	125,110
San Francisco General	San Francisco	CA	582	332		124,931		103%	80,000	199,287	279,287
San Joaquin	Stockton	CA	230	209	7,846	51,923	2,292	68%	51,953	104,866	156,819
San Mateo County General	San Mateo	CA	269	240	3,731	77,839		89%	21,229	79,109	100,338
Santa Clara Valley	San Jose	CA	722	533	15,970	130,987	3,213	67%	73,407	252,756	326,163
South Louisiana Medical Center	Houma	LA	201	158	8,718	40,070	2,374	70%	33,960	102,650	136,610
St.Luke's Roosevelt	New York	NY	1,354	1,354	40,043	430,907	4,611	87%	120,128	292,465	412,593
Tampa General	Tampa	FL	770	694	25,238	197,324	6,377	78%	49,579	18,457	68,036
Temple University	Philadelphia	PA	504	444	16,544	131,166	2,167	81%	42,584		42,584
Truman Medical Center	Kansas City	MO	308	247	12,363	67,812	2,863	75%	35,905	179,434	215,339
U of Chicago	Chicago	IL	652	543	21,985	165,990	2,866	84%	48,900	221,689	270,589
U of New Mexico	Albuquerque	NM	344	290	15,326	81,309	3,865	77%	41,067	132,842	173,909
UMDNJ	Newark	NJ	533	456	14,488	141,853	2,543	85%	51,775	106,569	158,344
Univ of Cincinnati	Cincinnati	OH	683	626	22,878	181,344	2,739	79%	55,043	154,489	209,532
University of Nebraska	Omaha	NE	412	312	9,806	79,093	1,272	69%	20,860	207,432	228,292
UT Galveston	Galveston	TX	821	821	27,272	223,613	4,349	75%	62,886	276,013	338,899
Westchester County	Valhalla	NY	633	633	18,851	211,583	839	92%	26,322	111,375	137,697
Wishard Memorial Hospital	Indianapolis	IN	573	415	15,676	104,072	3,204	69%	87,841	384,401	472,242
Total			**29,988**	**31,533**	**1,178,111**	**9,586,311**	**217,536**		**3,480,264**	**9,727,925**	**13,208,189**
Average			**588**	**526**	**19,988**	**159,772**	**4,183**	**82%**	**71,028**	**190,744**	**254,004**
Count		**60**	**51**	**60**	**59**	**60**	**52**	**58**	**49**	**51**	**52**
Minimum			**84**	**84**	**118**	**26,033**	**800**	**62%**	**49**	**833**	**833**
Maximum			**2,045**	**1,454**	**73,410**	**483,342**	**15,490**	**103%**	**261,067**	**687,029**	**854,155**

Table 2-6 Utilization

epidemic and the rise in drug abuse, violence, homelessness, mental illness, and poverty have combined to place heavier and heavier demands on safety net hospitals.

As occupancy rates for the hospital industry in general have dropped or remained level, occupancy rates for NAPH member hospitals have continued to grow, and remain much higher than other hospitals (See Figure 2-7). In 1988, occupancy rates averaged 82% for NAPH hospitals, while other short term general hospitals averaged just 66%. For some NAPH hospitals, occupancy rates topped 100%, forcing some of them to add beds to wards, holding areas and hallways to accommodate the numbers of patients seeking care (See Table 2-6).

NAPH hospitals provide a tremendous amount of inpatient and outpatient care, as illustrated in Table 2-6. Averaging 526 staffed beds, NAPH members provided in 1988 an average of more than 19,968 admissions and 159,772 inpatient days. These hospitals averaged 4,183 births per hospital. On the outpatient side, NAPH hospitals provided an average of more than 71,000 ER visits, and more than 190,000 clinic visits.

NAPH hospitals' volume of service far exceeds the volume reported by other short term general hospitals. In 1988, the average general hospital provided just over 5,600 admissions, 664 births, and 48,000 outpatient visits (See Table 2-7). NAPH hospitals provide more than 6 times the number of births than the average acute care hospital, more than three and a half times as many admissions, more than 5 times as many outpatient clinic visits and almost 5 times as many ED visits. It is also worth noting that NAPH hospitals reported an average length of stay of 8.1 days, as compared with 7.2 days for the average general hospital. This longer length of stay reflects in part the differences in the patient population between these groups of hospitals.

Patients seen in NAPH hospitals have longer stays due to several factors. Patients in safety net hospitals frequently have had limited access to ongoing medical care. They therefore tend to be sicker upon admission and often present with multiple diagnoses. In addition, patients in public hospitals often stay in the hospital past the medically necessary time, because of lack of suitable supports in the home environment, and lack of alternate placement facilities. As the number of admissions per NAPH hospital has risen since 1986, admissions per NAPH hospital remain well above the average for other short term general hospitals (See Figure 2-8).

Another illustration of the scope of safety net hospitals is reflected in Tables 2-8 and 2-9. These tables show the volume of services provided by safety net hospitals in several selected cities, compared with that of all hospitals within these cities. In each city, NAPH member hospitals represent a small portion of the hospitals in the city, but provide a much larger share of health care services. In all cities but one,

NAPH Versus Other Short–Term General Hospitals

	NAPH	Other
Hospitals	60	5,579
Staffed Beds	526	170
Admissions	19,968	5,643
Occupancy Rate	82.0%	65.5%
Average Daily Census	438	111
Average Length of Stay	8.1	7.2
Surgical Operations	8,360	3,839
Births	4,183	664
Newborn Days	11,017	1,839
Emergency Dept. Visits	71,026	14,584
Clinic Visits	190,744	34,069

Per Hospital, in 1988

Table 2-7 NAPH versus Other Short Term General Hospitals

Mothers waiting for room upstairs to deliver at the OB/GYN Emergency Room at Harbor/UCLA.

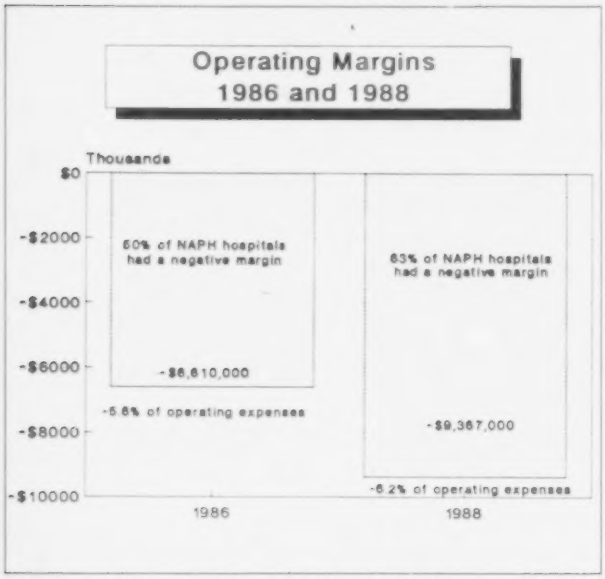


Figure 2-6 Operating Margins, 1986 and 1988

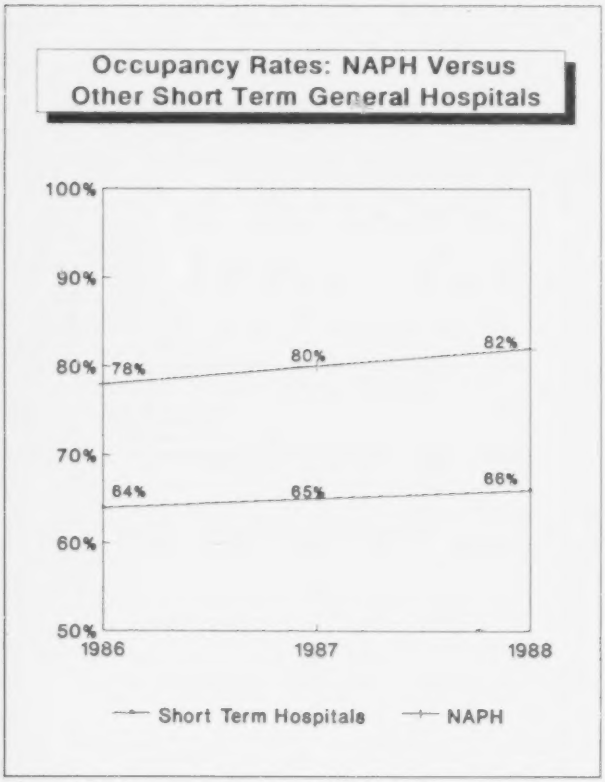


Figure 2-7 Occupancy Rates for NAPH and Other Short Term General Hospitals

NAPH hospitals had a higher occupancy rate than other hospitals.

The volume of care provided by safety net hospitals, particularly in comparison with other hospitals, portrays the essential nature of these hospitals, as well as the importance of keeping these hospitals operating and financially viable.

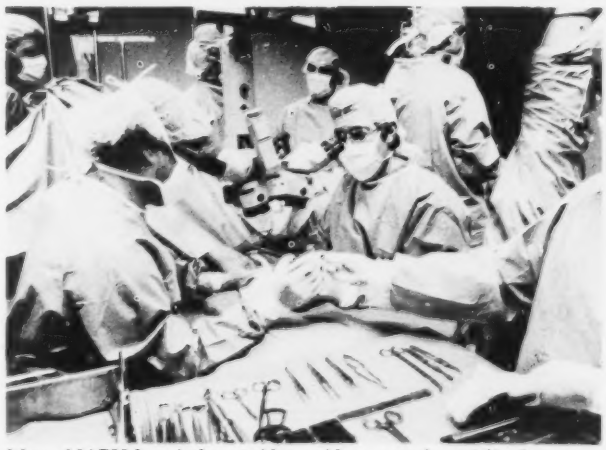
Services Provided

In addition to serving as a provider of care to the medically disenfranchised, NAPH member hospitals also provide a wide range of services to their communities, often offering services that are too costly or financially draining for other hospitals to provide. Most NAPH hospitals offer an extensive array of services, and are more likely than other general hospitals to offer many medical services (See Figure 2-9). NAPH hospitals are more likely to offer trauma, alcoholism, outpatient, psychiatric, outpatient rehabilitation, and other services. Seventy-four percent of NAPH hospitals provided trauma services, as compared with just 13% of other acute hospitals. In addition, NAPH hospitals were more likely to have cardiac catheterization labs, open-heart surgery programs, and organ transplant programs than were other hospitals.

Many of these services are associated with high proportions of uninsured patients, making them unattractive to other hospitals. Many community hospitals have declined to offer some of these services, or have discontinued providing services that attract high numbers of uninsured patients. This leaves the safety net hospital to carry an increasing share of the uninsured.

Special Needs of Safety Net Hospital Patients

The patients treated in safety net hospitals often have special needs, and present unique challenges. In addition to several special groups of patients, such as patients with AIDS (See Chapter 5) and drug abusers (See Chapter 6), public hospital patients have several other distinctive features that challenge the institutions charged with providing their care.



Many NAPH hospitals provide a wide range of specialized services, like this microsurgery being performed at Bellevue Hospital Center. *Photo by Joseph Guardino*

Public Hospital Services Compared with Total Community Services – 1988

City	Hospitals NAPH	Hospitals Total	Hospitals %	Beds NAPH	Beds Total	Beds %	Admissions NAPH	Admissions Total	Admissions %	Occupancy Rate NAPH	Occupancy Rate Total
Atlanta	1	16	6%	936	4,982	19%	40,693	195,242	21%	77%	74%
Chattanooga	1	11	9%	522	1,670	31%	25,305	58,679	43%	79%	60%
Chicago	2	46	4%	1,544	14,828	10%	56,394	449,916	13%	72%	67%
Cincinnati	1	13	8%	626	4,934	13%	22,878	174,207	13%	79%	69%
Dallas	1	22	5%	862	5,664	15%	38,817	200,555	19%	80%	64%
D.C.	1	12	8%	420	4,716	9%	13,832	172,933	8%	79%	76%
Houston	1	34	3%	811	10,542	8%	41,580	336,696	12%	83%	60%
Indianapolis	1	9	11%	415	3,930	11%	15,676	147,772	11%	69%	74%
Kansas City	1	11	9%	247	3,310	7%	12,363	104,253	12%	75%	67%
Los Angeles	6	60	10%	3,093	13,574	23%	134,918	497,052	27%	90%	65%
Memphis	1	10	10%	437	4,849	9%	22,456	153,232	15%	89%	76%
Milwaukee	1	12	8%	338	3,918	9%	11,570	143,063	8%	77%	67%
Newark	1	6	17%	456	2,220	21%	14,488	81,023	18%	85%	82%
New York	12	68	18%	8,716	34,419	25%	273,764	1,119,191	24%	91%	89%

Table 2-8 Public Hospital Services Compared with Total Community Services

Severity of Illness and Social Severity. Poverty is a fact of life for many patients who rely on public hospitals for medical care. The impact of poverty on health status is well documented. A 1987 study of patients admitted to 5 Massachusetts hospitals concluded that patients of low socioeconomic status had longer lengths of stay, and required more resources to treat in the hospital than did higher income patients.[5] Lack of access to preventive and routine health care causes many poor people to delay seeking care until they are quite ill. Poor nutrition contributes to more difficult recovery from many illnesses. Patients of lower socioeconomic status have also been associated with multiple diagnoses. For others, their illegal alien status prevents them from seeking care for fear of being discovered and deported. All of these factors result in public hospitals having a sicker patient population, one that requires more intensive treatment and longer stays.

In addition to severity of illness, and the medical consequences associated with the medically disenfranchised, the patient population in safety net hospitals also requires significantly more social services than do patients in other hospitals. Although difficult to measure, public hospitals report more social service interventions on behalf of patients, in discharge planning, and in education and patient teaching. Public hospitals report a high number of "administrative days," days for which a patient is medically ready to be discharged, but for whom no appropriate placement could be found (see Chapter 7).

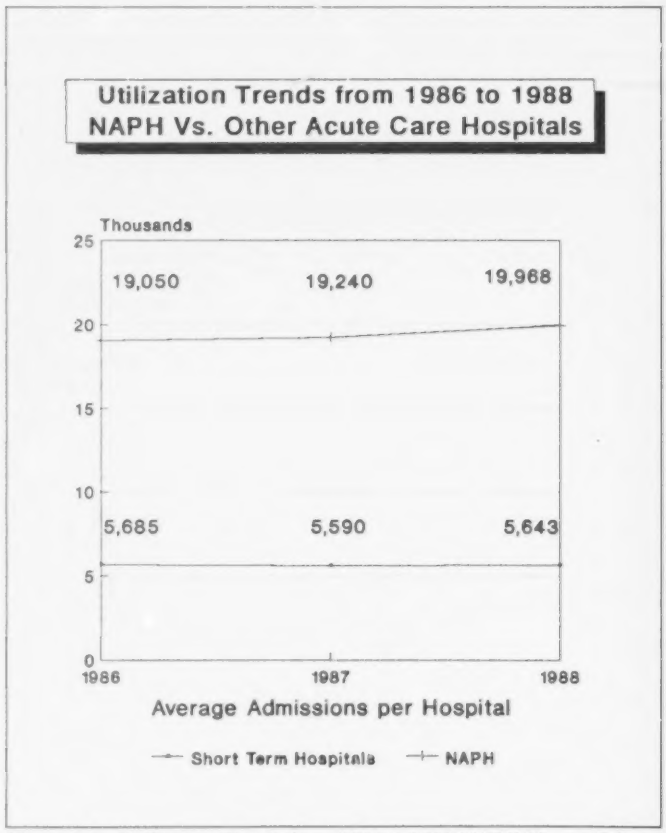


Figure 2-8 Utilization Trends from 1986 to 1988 NAPH Versus Other Acute Care Hospitals

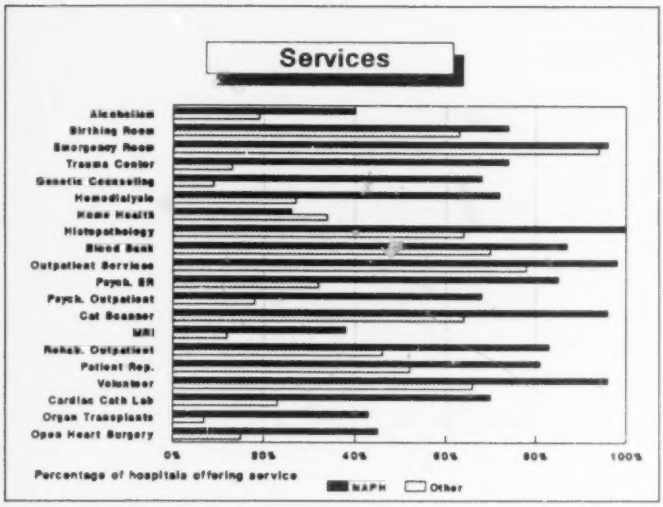


Figure 2-9 Services

Homelessness. The homeless present another challenge to our health care system as a whole, and particularly to public hospitals. While the numbers of homeless patients are difficult to measure, most public hospitals agree that the numbers are on the rise. The factors associated with poverty—things that complicate the health care needs of the poor—are even more significant in the homeless population. Neglect of health, poor nutrition, extremely poor living conditions, a frequent lack of recognition of symptoms of illness, and the complications of alcohol abuse and mental illness, all contribute to the health care problems of the homeless.

In Bellevue Hospital in New York City, homelessness is a major factor in the lives of a good portion of its patient population. In a recent study of the issue, Bellevue discovered that 20% of all patients discharged were homeless.[6] These patients required stays of about twice that of other patients. Even after controlling for DRG, hospital stays were still much longer than for non-homeless patients. The homeless population at Bellevue experienced a higher proportion of drug use, alcohol use, HIV illness, mental illness, and noncompliance with treatment as compared with other patients. Throughout the country, homelessness is increasing, and the health care needs of the homeless will be a challenge for public hospitals and community health centers for the foreseeable future.

Prison Services. Many safety net hospitals provide health care services to the inmates of state and local prisons, either under contract with the operating entity or based on the hospital's traditional mission of caring for all patients regardless of insurance status. The health care needs of the prison population also reflect the role poverty plays in overall health and well-being. Many prisoners enter prison after years without medical evaluation or attention and with multiple underlying medical problems, making their health care needs more complex.

In some cases, the public hospital is responsible for managing on-site health care services. In other instances, the hospital provides inpatient care and ambulatory services within the hospital structure. In all, 66% of NAPH hospitals (38 hospitals) have a contract to provide health services to a prisoner population. These hospitals averaged 439 inpatient admissions and 5,671 outpatient visits per hospital for prisoners during 1988. Twenty-nine percent (17 hospitals) have dedicated prison inpatient wards, averaging 31 beds.

Public Hospital Services Compared with Total Community Services – 1988

City	Beds NAPH	Beds Total	Beds %	Births NAPH	Births Total	Births %
Atlanta	936	4,982	19%	8,123	24,317	33%
Chattanooga	522	1,670	31%	3,756	5,677	66%
Chicago	1,544	14,828	10%	8,590	52,719	16%
Cincinnati	626	4,934	13%	2,739	20,627	13%
Dallas	862	5,664	15%	14,543	34,692	42%
D.C.	420	4,716	9%	1,890	19,782	10%
Houston	811	10,542	8%	14,050	49,154	29%
Indianapolis	415	3,930	11%	8,590	16,031	54%
Kansas City	247	3,310	7%	2,863	12,053	24%
Los Angeles	3,093	13,574	23%	32,584	84,577	39%
Memphis	437	4,849	9%	7,545	17,309	44%
Milwaukee	338	3,918	9%	800	15,348	5%
New York	8,716	34,419	25%	37,978	127,276	30%
Newark	456	2,220	21%	2,543	7,767	33%
Tampa	694	9,123	8%	6,377	21,154	30%

Table 2-9 Public Hospital Services Compared with Total Community Services

[1]"The Future of the Public-General Hospital: An Agenda for Transition" Report of the Commission on Public-General Hospitals, Hospital Research and Education Trust. Chicago, IL 1978.

[2]Source: AHA Hospital Statistics, 1989-90 edition.

[3]Jim Mongan, testimony before the House Ways and Means Subcommittee on Health, April 4, 1990.

[4]"Uncompensated and Unsponsored Hospital Care: A Fact Sheet" American Hospital Association Office of Public Policy Analysis, June 1990.

[5]Epstein, Arnold M. "Do the Poor Cost More? A Multi-hospital Study of Patients' Socioeconomic Status and Use of Hospital Resources." *The New England Journal of Medicine* April 19, 1990.

[6]Paine, Martha "Homeless Patient Characteristics and Utilization," Bellevue Hospital Memorandum, April 4, 1990.

Public Hospitals as Family Doctor for the Poor

For many of the poor—the unemployed and the working poor—as well as for middle-income people who lack adequate health insurance, health care and routine primary care in particular, can be difficult to obtain. Without access to primary care physicians, many of these people rely entirely on public hospitals for their health care, utilizing public hospital emergency departments and outpatient clinics as their "family doctor." In spite of long waiting times, overcrowding, staff shortages, and lack of adequate equipment, the number of patients using public hospital clinics continues to grow.

Primary Care in the Public Hospital Setting

NAPH member hospitals provided an average of more than 71,000 ED visits and 190,000 clinic visits in 1988 (See Table 3-1). As inpatient services in safety net hospitals have become more and more crowded, and as the number of people without access to community based health care has increased, the demand for outpatient services in public hospitals has increased (See Figure 3-1 and Table 3-2). Many public hospitals offer an array of ambulatory services, with in-hospital clinics as well as satellite clinics in the community provided to meet demand. In some communities, the increase in demand for outpatient services has been tremendous. NAPH hospitals also provide a much higher volume of clinic services than do other hospitals. In selected cities, the volume of outpatient care provided by safety net hospitals also far outweighs service provided by other hospitals (See Table 3-3).

Financial Implications for Outpatient Services

For public hospitals, provision of outpatient services is a costly endeavor. Outpatient services represent a large portion of the hospital gross revenues of NAPH hospitals; on average, 22% of total hospital gross revenues are attributable to outpatient services. A high proportion of outpatient services is provided to patients without any form of insurance. For NAPH hospitals, more than half of all visits were unsponsored (See Figure 3-2). In addition, Medicaid, which represents one fourth of all public hospital outpatient visits—and a higher proportion in some hospitals—typically pays well below cost. Hospitals, therefore, lose money on three-quarters of their outpatient visits.

Although hospitals receive payment enhancements on the inpatient side under Medicare and Medicaid for providing care to a disproportionate share of low income patients, no adjustment is available for outpatient services. This type of adjustment is being considered by Congress, and would be a significant help to hospitals providing this type of care.

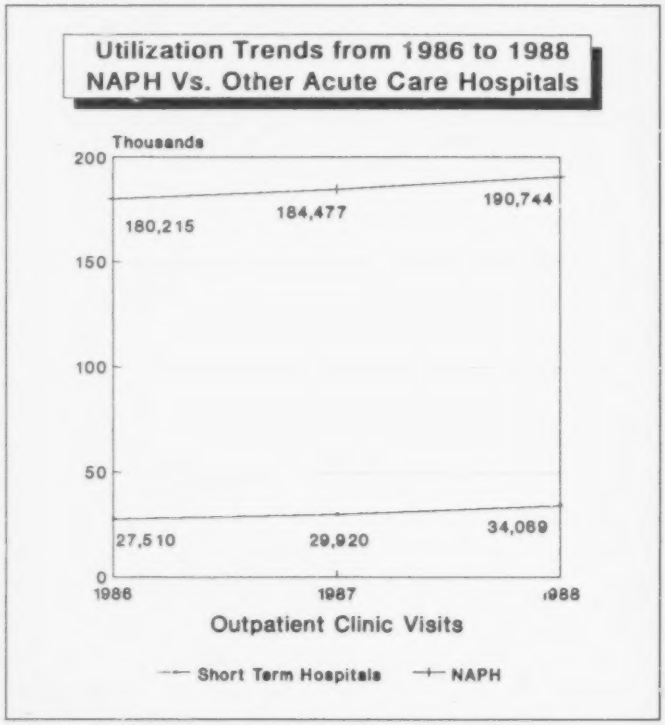


Figure 3-1 Utilization Trends from 1986 to 1988 NAPH Versus Other Acute Care Hospitals

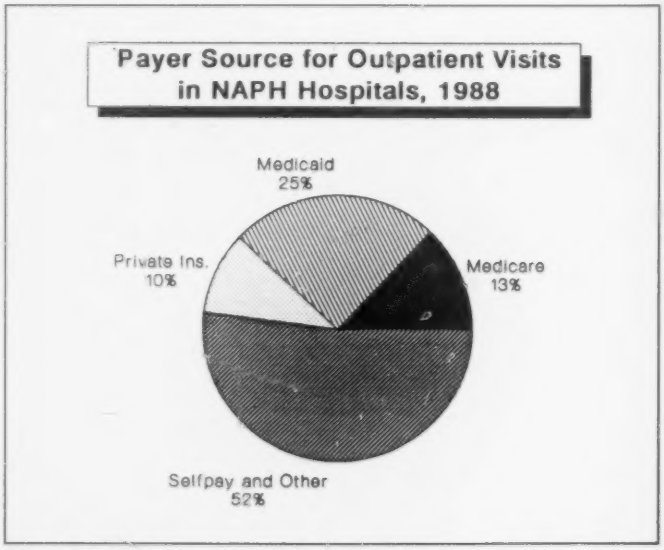


Figure 3-2 Payer Source for Outpatient Visits

Outpatient Utilization – 1988

Hospital	City	State	ED Visits	Outpatient Clinic	Total Outpatient
Amarillo Hospital District	Amarillo	TX	43,200	94,282	137,482
Boston City Hospital	Boston	MA	65,144	134,749	199,893
Cook County Hospital	Chicago	IL	252,237	397,588	649,825
D.C. General	Washington	DC	85,032	109,467	194,499
Erlanger	Chattanooga	TN	94,731	41,286	136,017
Grady	Atlanta	GA	261,067	593,088	854,155
Harborview Medical Center	Seattle	WA	40,888	266,405	307,293
Harris County Hospital	Houston	TX	99,122	489,744	588,866
Health Sciences Center	Syracuse	NY	42,442	188,237	230,679
Hilo Hospital	Hilo	HI	15,498	47,679	63,177
Hurley Medical Center	Flint	MI	38,865	57,649	96,514
Jackson Memorial Hospital	Miami	FL	123,661	239,910	363,571
Kula Hospital	Kula	HI	49	1,017	1,066
LAC–Harbor–UCLA	Torrance	CA	83,048	209,185	292,233
LAC–High Desert Hospital	Lancaster	CA		39,471	39,471
LAC–USC Medical Ctr.	Los Angeles	CA	190,746	366,704	557,450
Maricopa Medical Center	Phoenix	AZ	60,286	157,702	217,988
MD Anderson	Houston	TX		283,823	283,823
Medical Center of Central Georgia	Macon	GA	39,775	126,546	166,321
Memorial Hospital	Hollywood	FL	79,202	2,758	81,960
Memorial Medical Center	Savannah	GA	43,270	43,919	87,189
Merrithew Memorial Hospital	Martinez	CA	24,435	163,572	188,007
Milwaukee Medical Complex	Milwaukee	WI	39,947	175,729	215,676
Nassau County Medical Center	East Meadow	NY	77,312	179,524	256,836
NYC– Bellevue Hospital	NY	NY	92,100	325,766	417,866
NYC– City Elmhurst	Queens	NY	107,625	321,692	429,317
NYC– Harlem Hospital	NY	NY	94,701	667,029	761,730
NYC– North Central Bronx	Bronx	NY	68,370	161,701	230,071
NYC– Queens Hospital Center	Jamaica	NY	87,328	234,034	321,362
Parkland Memorial Hospital	Dallas	TX	137,179	373,178	510,357
Pontiac General Hospital	Pontiac	MI	21,580	105,876	127,456
Regional Medical Center	Memphis	TN	86,436	98,896	185,332
Riverside General Hospital	Riverside	CA	51,314	110,397	161,711
Samuel Mahelona Memorial	Kapaa	HI		833	833
San Bernardino County	San Bernardino	CA	30,235	94,875	125,110
San Francisco General	San Francisco	CA	80,000	199,287	279,287
San Joaquin	Stockton	CA	51,953	104,666	156,619
San Mateo County General	San Mateo	CA	21,229	79,109	100,338
Santa Clara Valley	San Jose	CA	73,407	252,756	326,163
South Louisiana Medical Center	Houma	LA	33,960	102,650	136,610
St.Luke's Roosevelt	New York	NY	120,128	292,465	412,593
Tampa General	Tampa	FL	49,579	18,457	68,036
Temple University	Philadelphia	PA	42,584		42,584
Truman Medical Center	Kansas City	MO	35,905	179,434	215,339
U of Chicago	Chicago	IL	48,900	221,669	270,569
U of New Mexico	Albuquerque	NM	41,067	132,842	173,909
UMDNJ	Newark	NJ	51,775	106,569	158,344
Univ of Cincinnati	Cincinnati	OH	55,043	154,489	209,532
University of Nebraska	Omaha	NE	20,860	207,432	228,292
UT Galveston	Galveston	TX	62,886	276,013	338,899
Westchester County	Valhalla	NY	26,322	111,375	137,697
Wishard Memorial Hospital	Indianapolis	IN	87,841	384,401	472,242
Total			**3,480,264**	**9,727,925**	**13,208,189**
Average			**71,026**	**190,744**	**254,004**
Count		**52**	**49**	**51**	**52**
Minimum			**49**	**833**	**833**
Maximum			**261,067**	**667,029**	**854,155**

Table 3-1 Outpatient Utilization

Changes in Outpatient Utilization from 1987 to 1988

HOSPITAL	CITY	ST	1987 ED	1988 ED	1987 Clinic	1988 Clinic	1987 Total	1988 Total
Boston City Hospital	Boston	MA	59,988	65,144	114,465	134,749	174,453	199,893
Cook County Hospital	Chicago	IL	260,684	252,237	364,656	397,588	625,340	649,825
DC General	Washington	DC	86,511	85,032	101,184	109,467	187,695	194,499
Grady Memorial	Atlanta	GA	251,432	261,067	497,563	593,088	748,995	854,155
Harborview Medical Center	Seattle	WA	40,045	40,888	101,850	266,405	141,895	307,293
Harris County	Houston	TX	46,222	99,122	486,498	489,744	532,720	588,866
Hawaii Hospital System	Honolulu	HI	14,866	15,547	33,307	49,529	48,173	65,076
Hurley Medical Center	Flint	MI	39,491	38,865	33,557	57,649	73,048	96,514
LAC–Harbor UCLA	Torrance	CA	95,284	83,048	153,300	209,185	248,584	292,233
Maricopa Medical Center	Phoenix	AZ	68,420	60,286	131,211	157,702	199,631	217,988
Memorial Medical Center	Savannah	GA	48,659	43,270	45,376	43,919	94,035	87,189
Merrithew Memorial Hospital	Martinez	CA	25,981	24,435	118,962	163,572	144,943	188,007
Milwaukee County Med. Complex	Milwaukee	WI	39,947	39,947	163,561	175,729	203,508	215,676
Nassau County	East Meadow	NY	80,992	77,312	179,412	179,524	260,404	256,836
NYC–Bellevue	New York	NY	107,695	92,100	249,032	325,766	356,727	417,866
NYC–City at Elmhurst	Elmhurst	NY	106,901	107,625	281,871	321,692	388,772	429,317
NYC–Harlem Hospital	New York	NY	86,457	94,701	561,531	667,029	647,988	761,730
NYC–Queens County	Jamaica	NY	89,203	87,328	173,200	234,034	262,403	321,362
Parkland Memorial Hospital	Dallas	TX	157,268	137,179	197,481	373,178	354,749	510,357
Pontiac General Hospital	Pontiac	MI	21,815	21,580	173,274	105,876	195,089	127,456
Regional Medical Center	Memphis	TN	63,260	86,436	109,575	98,896	172,835	185,332
Riverside General Hospital	Riverside	CA	50,480	51,314	83,555	110,397	134,035	161,711
San Bernardino County	San Bernardino	CA	32,030	30,235	83,652	94,875	115,682	125,110
Santa Clara Valley	San Jose	CA	71,080	73,407	222,024	252,756	293,104	326,163
St. L uke's Roosevelt	New York	NY	120,128	120,128	291,331	292,465	411,459	412,593
Tampa General Hospital	Tampa	FL	51,401	49,579	18,161	18,457	69,562	68,036
Truman Medical Center– West	Kansas City	MO	38,870	35,905	124,493	179,434	163,363	215,339
University Hospital	Newark	NJ	54,487	51,775	30,341	106,569	184,828	158,344
University Hospital	Omaha	NE	18,599	20,860	172,489	207,432	191,088	228,292
Univ. New Mexico Hospital	Albuquerque	NM	36,697	41,067	105,689	132,842	142,386	173,909
Univ.Chicago Hospitals	Chicago	IL	49,375	48,900	207,554	221,669	256,929	270,569
Univ. of Cincinnati	Cincinnati	OH	73,705	55,043	115,891	154,489	189,596	209,532
Univ. Texas Medical Branch	Galveston	TX	63,248	62,886	248,183	276,013	311,431	338,899
Westchester County	Valhalla	NY	17,680	26,322	103,836	111,375	121,516	137,697
Wishard Memorial	Indianapolis	IN	83,806	87,841	278,644	384,401	362,450	472,242
Total			2,552,707	2,568,411	6,456,709	7,697,495	9,009,416	10,265,906
Average			72,934	73,383	184,477	219,928	257,412	293,312
Count			35	35	35	35	35	35
Minimum			14,866	15,547	18,161	18,457	48,173	65,076
Maximum			260,684	261,067	561,531	667,029	748,995	854,155

Table 3-2 Changes in Outpatient Utilization from 1987 to 1988

Public Hospital Services Compared with Total Community Services – 1988

City	Hospitals NAPH	Hospitals Total	Hospitals %	OPD Visits NAPH	OPD Visits Total	OPD Visits %	ER Visits NAPH	ER Visits Total	ER Visits %
Atlanta	1	16	6%	593,088	1,236,565	48%	261,067	489,787	53%
Chattanooga	1	11	9%	41,286	116,274	36%	94,731	178,014	53%
Chicago	2	46	4%	619,257	3,787,293	16%	301,137	1,073,563	28%
Cincinnati	1	13	8%	154,489	853,741	18%	55,043	393,589	14%
Dallas	1	22	5%	373,178	940,140	40%	137,179	399,999	34%
D.C.	1	12	8%	109,467	894,308	12%	85,032	460,595	18%
Houston	1	34	3%	489,744	1,570,646	31%	99,122	489,868	20%
Indianapolis	1	9	11%	384,401	996,042	39%	87,841	287,532	31%
Kansas City	1	11	9%	179,434	660,429	27%	35,905	196,484	18%
Memphis	1	10	10%	98,896	522,048	19%	86,436	308,862	28%
Milwaukee	1	12	8%	175,729	1,000,067	18%	39,947	352,274	11%
Newark	1	6	17%	106,569	411,489	26%	51,775	171,724	30%
Syracuse	1	8	13%	188,237	626,584	30%	42,442	213,244	20%

Table 3-3 Public Hospital Services Compared With Total Community Services

Without access to primary care physicians, many people rely on public hospitals for all their health care needs.
Courtesy of San Mateo County General Hospital

A recent article entitled "Gridlock Stalls Public Clinics" describes the problem in clinics across the country. "Demand for outpatient services has outstripped capacity to such an extent that the public health delivery system may be spinning toward its breaking point."

- In Chicago, **Cook County Hospital** is struggling to meet increasing demands for service. A staff physician at the clinic said, "Some inpatients wait up to eight hours for attention, and other patients have waited three to four months for an appointment in certain clinics." Dr. John Lee Clowe of the AMA states that, "A place like Cook County (Clinic) is the largest, dizziest, toughest place to work in the world, but the staff are extremely dedicated and hardworking."
- In Miami, **Jackson Memorial Hospital** is facing increasing demand spurred on by violence, AIDS, drugs, and an increase in the population of illegal aliens. Although they lose money on outpatient services, hospitals prefer to provide outpatient services early on, to avoid having to treat the same patients later in the emergency room or intensive care units, with their illnesses in more advanced stages.
- **Harborview Medical Center** in Seattle, Washington, once operated a successful outpatient program, including an outreach component and several satellite clinics. Today, the hospital is under tight budget constraints and is not meeting the full demand. The hospital attributes the increase primarily to AIDS and homelessness.

Source: "Gridlock Stalls Public Hospitals" Healthweek, July 30, 1990.

4

Emergency and Trauma Services

Emergency department crowding has become the focus of national attention as hospitals across the country find their resources increasingly strained by the problems of escalating drug use and related violence, the AIDS epidemic, high levels of uncompensated care and, in some states, a strict regulatory environment which has led to bed decertification. In some large cities, emergency department (ED) closures and threatened dismantling of trauma service networks have placed an increased burden on those hospitals that continue to provide emergency and trauma care. NAPH member hospitals, in their role as safety net institutions, are not in a position to close their EDs. Instead, they often find themselves filling the gap left by area hospitals that have reduced or discontinued services.

In an effort to assess the level of emergency and trauma care services provided by NAPH hospitals, and to measure the impact of ED and hospital crowding on quality of care, The National Public Health and Hospital Institute (NPHHI) conducted a study of the NAPH membership. The study requested information for the period October 1, 1987 through September 30, 1988. The following chapter describes the situation among the fifty-three responding hospitals.

Emergency Services

Emergency Department Characteristics. NAPH hospitals are major providers of emergency services averaging almost 72,000 ED visits during the year of study. In contrast, the annual volume of ED visits in U.S. acute care hospitals (14,584) was about one-fifth of that for NAPH facilities (Table 4-1). In recent years, the amount of emergency care provided in NAPH facilities has grown steadily for most member hospitals. About three-fourths of hospitals reported a rise in ED visits from 1985 to 1988, averaging increases of 12%. Emergency departments often serve as the primary source of admission to NAPH hospitals, with an average of 53% of all admissions occurring through the ED. In several hospitals, more than 70% of all admissions occurred through the ED. Seventeen percent (17%) of patients seen in the ED were subsequently admitted for inpatient care. Two percent (2%) of ED patients were transfer patients from other facilities, and 17% arrived by ambulance.

Hospital and ED Crowding. Generally, ED crowding occurs when large numbers of ED patients are ready, but unable, to be admitted to either a floor or ICU bed. Hospital emergency department directors were asked to report the average length of time admitted patients must be held in the ED after their initial evaluation is complete, admission orders are written and the patient would otherwise have been transported to an inpatient unit. Almost two-thirds (62%) of NAPH member hospitals reported average "holding" times of two hours or more (Table 4-2). Periodic waits for a floor bed of twelve or more hours were reported by 58% of hospitals while waits of one day were not uncommon; fifty percent of responding hospitals reported periodic waits of twenty-four or more hours.

NAPH facilities must hold critical care patients in the ED when no vacant or appropriately staffed ICU bed is available. Although hospitals reported that the average holding time for critically ill or injured patients in their emergency departments was less than those noted for floor patients (3.2 hours versus 5.6 hours, respectively), 45% of hospitals reported that critical care patients are sometimes held in their EDs for twelve hours or more. Periodic ED holding times for critical care patients of twenty-four hours or more occurred in 29% of institutions.

Emergency departments across the nation are overcrowded and financially strapped due to an increase in drug use and related violence, the AIDS epidemic, and high levels of uncompensated care. *Courtesy of the Regional Medical Center at Memphis*

To estimate how frequently crowding occurs in NAPH emergency departments, we asked ED directors to report the number of days during the month of August 1988 that they were required to "hold" admitted

Emergency Department Characteristics
NAPH Hospitals – 1988

No. of Hospitals Reporting	53
Average Annual ED Visits	71,774
Average Percent of ED Visits Arriving by Ambulance	16.7%
Average Percent of ED Patients Admitted for Inpatient Care	17.0%
Average Percent of Transfer Patients from Other Facilities	2.4%
Average Percent of Hospital Inpatient Admissions through the ED	52.5%
Change in Volume of Annual ED Visits (1/1/85 – 1/1/88):	
Percent of Hospitals Reporting Increased Visits	74.0%
Average Percent of Increased Visits	11.9%

Table 4-1 Emergency Department Characteristics

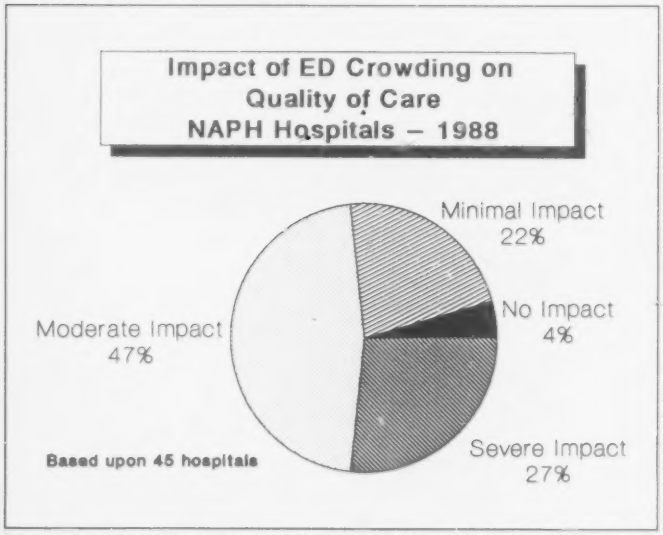


Figure 4-1 Impact of ED Crowding on Quality of Care

ED patients in their departments four or more hours due to lack of vacant or staffed inpatient beds. NAPH hospitals met this criterion an average of 15.7 days during the month. If reports of "holding" for at least five days of the month can be considered indicative of recurring crowding problems and not just episodic occurrences, slightly more than three-fourths of NAPH hospitals experienced a significant problem with crowding during the reference month. Furthermore, in one-fourth of hospitals crowding occurred every day of the month.

ED Financial Characteristics. With the emergency department as the primary route of entry for admission to many public hospitals, examining the adequacy of revenues generated by ED patients is critical to these institutions. Severity of illness and a myriad of social factors can have a significant impact on the level of resources needed to treat ED patients. In many NAPH emergency departments, the challenge of treating patients with multiple diagnoses is compounded by the problems of drug abuse, homelessness, and poverty. To assess the level of reimbursement NAPH members receive for all patients treated in their emergency departments, we asked hospitals to provide us with estimated collection rates for ED patients. Hospitals reported that they collect an average of forty-three cents per dollar of charges for all ED patients and about three fourths (71%) of hospitals collected 50 cents or less.

Measures to Manage Crowding. Hospitals identified from a list which options, if any, they had exercised at least one day (for either all or part of a 24-hour period) during August 1988 in response to crowding at their facility. The most frequently utilized option was transfer refusal, with 58% of NAPH members reporting that they had refused requests for inter-hospital transfers at least one day (Table 4-3). One-fourth (26%) indicated that they utilized this option at least 15 days during the month. Forty-two percent restricted access to some ambulance patients at least once and 34% reported using this option 5 days or more. Hospitals also indicated that they actively transferred patients to other hospitals (40%) or implemented diversion or "drive-by" status (33%) at least one day during the study month. Several NAPH facilities had adopted other options, which included "opening recovery rooms and other vacant

Hospital and ED Crowding Characteristics in NAPH Hospitals – 1988

Average Wait for a Floor Bed:	
Average Number of Hours	5.6
Percent Reporting Two or More Hours	62
Percent Reporting Six or More Hours	26
Periodic Wait for a Floor Bed:	
Average Number of Hours	31.6
Percent Reporting Twelve or More Hours	58
Percent Reporting Twenty–four or More Hours	50
Average Wait for an ICU Bed:	
Average Number of Hours	3.2
Percent Reporting Two or More Hours	50
Percent Reporting Six or More Hours	14
Periodic Wait for an ICU Bed:	
Average Number of Hours	18.7
Percent Reporting Twelve or More Hours	45
Percent Reporting Twenty–four or More Hours	29
Days of Crowding in August 1988:	
Average Number of Days	15.7
Percent Reporting Five or More Days	77
Percent Reporting Fifteen or More Days	50
Percent Reporting Thirty–one Days	25
No. of Hospitals Reporting	50

Table 4-2 Hospital and ED Crowding Characteristics on NAPH Hospitals

spaces" (4 hospitals), "restricting elective admissions" (2 hospitals), and "expediting discharges" (2 hospitals).

When hospital ED directors were asked to estimate on an ordinal scale how hospital crowding adversely influenced quality of care in their departments, three-fourths of respondents perceived the effect as moderate or severe (Figure 4-1). Just 4% felt that crowding had no impact on the quality of care rendered in their institutions.

Trauma Services

Trauma Center Characteristics. In addition to maintaining basic ED services, many NAPH member institutions operate specialized trauma centers to care for severely injured patients. Three-fourths of responding hospitals (76%) indicated that they operated separate trauma centers as of September 30, 1988 as compared to 13% of general, acute care hospitals nationwide. For those NAPH facilities in states or localities with an established process for trauma center designation, the overwhelming majority (78%) are designated as Level I according to American College of Surgeons criteria (Figure 4-2).

For those hospitals that did not operate designated trauma centers, we asked trauma directors to identify factors affecting the decision not to seek trauma center designation. The most frequently cited reason was that other hospitals in their service area were designated (19%) (Figure 4-3). Similar proportions of hospitals (13%) indicated that the high cost of staffing and operating a trauma center and difficulty in recruiting qualified personnel were factors.

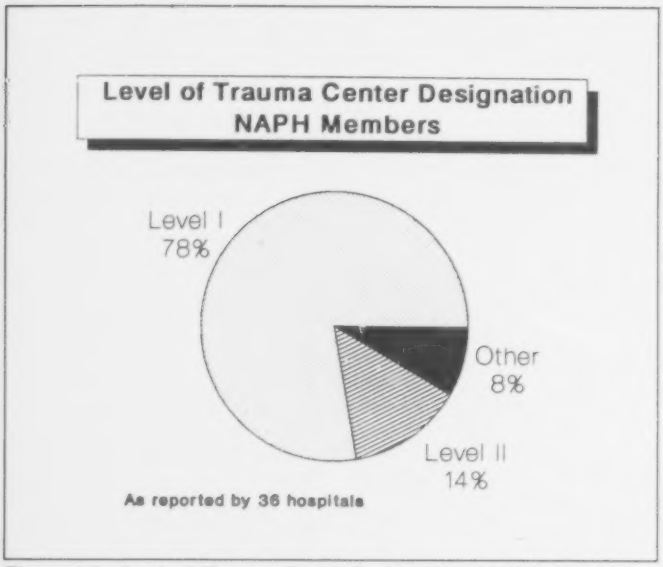


Figure 4-2 Level of Trauma Center Designation—NAPH Members

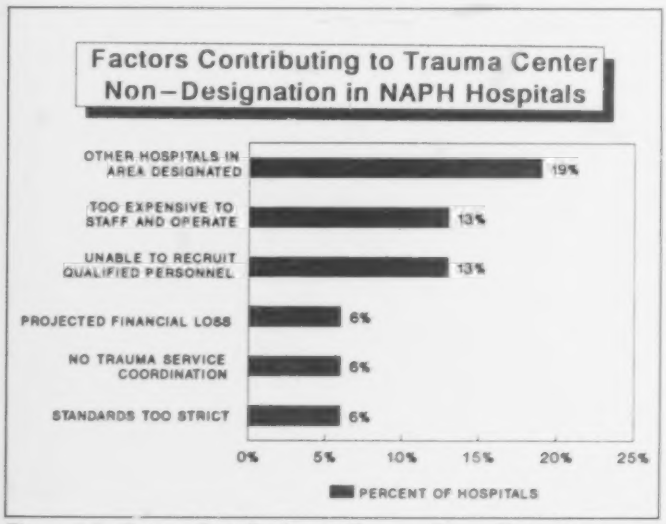


Figure 4-3 Factors Contributing to Trauma Center Designation in NAPH Hospitals.

Trauma Center Operations. The volume of trauma patients treated at NAPH hospitals averaged slightly less than 3,000 during the study year. Somewhat more than half of trauma patients were admitted (1,649) representing 16% of all inpatient admissions (Figure 4-4).

Potential Threats to Trauma Service Viability. We asked trauma center directors to estimate on an ordinal scale the effect of several potential threats to the viability of their hospital's trauma center. Inadequate financial support was perceived as the greatest potential threat, with 90% of directors reporting that insufficient state funding and 80% indicating that a lack of local monies had a moderate or severe effect (Figure 4-5). Almost three-fourths of directors (71%) felt that high levels of uncompensated care posed moderate or severe threats and 53% reported difficulties in staff recruitment and retention as having at least a moderate impact.

Implications. Our study documents that NAPH member hospitals, as high volume providers of emergency and trauma care, are confronted by a variety of environmental factors that may compromise their ability to provide these services. Hospital crowding has led to frequent, and often extended, delays in admission of ED patients and emergency department overload has compelled hospitals to implement diverse strategies to handle periods of excess demand. The financial burden placed on hospitals due to inadequate reimbursement for emergency care has been exacerbated as NAPH members delay elective admissions to make room for emergency patients.

As the nation's public hospitals face emergency department crowding and hospital gridlock, the ability of health care professionals to provide quality care under these conditions has been severely compromised. Furthermore, as public facilities are forced to divert patients because of ED overload and as hospital crowding becomes increasingly widespread and not unique to public institutions, patients may find access to emergency care difficult to find.

"The patients, staff and families involved in the care of our ED patients are put in a condition of compromise due to the bed shortage. . . [We] almost always have 20 admitted patients housed in the ED because of the bed shortage."
Jeff Lieto, Coney Island Hospital

"The men and women who staff our ED are working under incredible pressure. They cannot continue indefinitely; and when they finally exhaust their energy, loyalty and courage and resign—they cannot be replaced for no sane person would voluntarily take a job under these conditions."
Reynold Trowers, Harlem Hospital

"Intensive care beds are at a premium; some very serious situations have occurred due to holding these patients needing critical care services for extended periods of time in the ED."
Marlene Hudgin, Northwest Texas Hospital

Hospital Responses to Crowding
NAPH Hospitals – 1988

Options Utilized to Deal with Crowding:
(Days in August 1988)

Refuse Transfers:	
Average No. of Days	6.7
Percent Reporting One Day or More	58
Percent Reporting Five Days or More	37
Percent Reporting Fifteen Days or More	26
Transfer to Other Hospitals:	
Average No. of Days	4.0
Percent Reporting One Day or More	40
Percent Reporting Five Days or More	25
Percent Reporting Fifteen Days or More	11
Restrict ED Access to Some Ambulance Patients:	
Average No. of Days	5.8
Percent Reporting One Day or More	42
Percent Reporting Five Days or More	34
Percent Reporting Fifteen Days or More	18
Restrict ED Access to All Ambulance Patients:	
Average No. of Days	1.8
Percent Reporting One Day or More	33
Percent Reporting Five Days or More	12
Percent Reporting Fifteen Days or More	4
Other Options Utilized to Relieve Crowding:	
Average No. of Days	10.5
Percent Reporting One Day or More	60
Percent Reporting Five Days or More	80
Percent Reporting Fifteen Days or More	20
No. of Hospitals Responding	49

Table 4-3 Hospital Response to Crowding

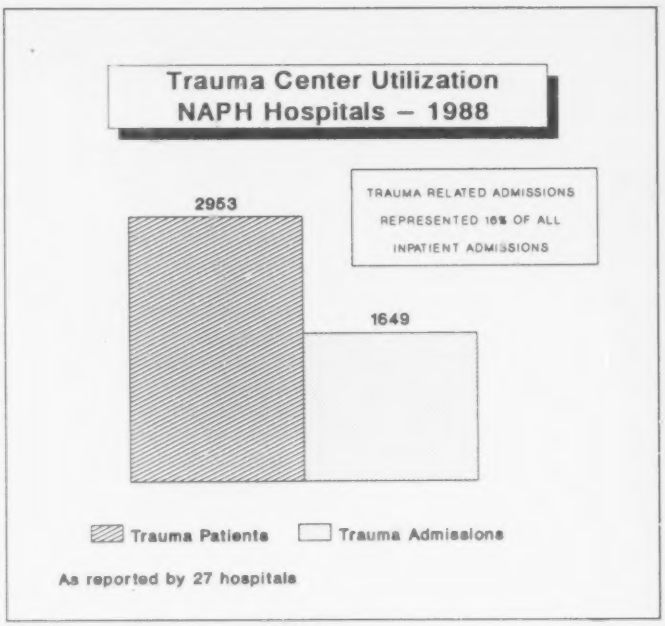


Figure 4-4 Trauma Center Utilization

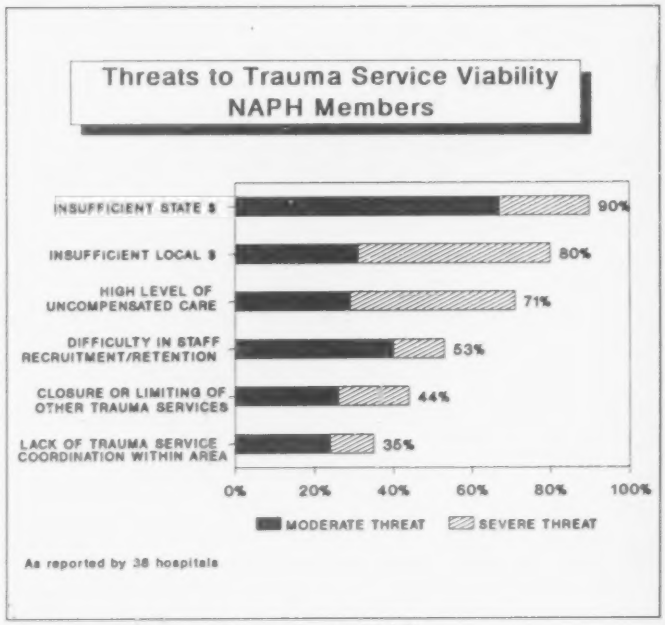


Figure 4-5 Threats to Trauma Service Viability

AIDS Care

Since the onset of the AIDS epidemic, NAPH member hospitals, by their mission, role, location, and services, have been called upon to treat growing numbers of persons with AIDS. This report describes the extent and consequences of that involvement. It presents findings for the NAPH membership from the 1988 version of the U.S. Hospital AIDS Survey and examines changes in the impact of the epidemic on NAPH hospitals since the project was initiated in 1985. Based on a substantial response, it also reports for the first time 1988 information on "other HIV" patients as well as those patients who meet the Centers for Disease Control (CDC) definition for AIDS.

This survey, which was conducted by NPHHI, is supported by the Robert Wood Johnson Foundation, the CDC, the American Foundation for AIDS Research, and the Agency for Health Care Policy and Research. This study represents the only ongoing major national investigation to date to document the course of the AIDS epidemic as it affects hospitals. Six hospital associations have participated in this effort including the NAPH, the Council of Teaching Hospitals, the National Association of Children's Hospitals and Related Institutions, the Catholic Health Association, the National Rural Health Association and the National Council of Community Hospitals. Information has been collected from 1985, 1987 and 1988, with the 1988 database incorporating responses from over 700 institutions treating more than 23,000 people with AIDS during that year.

Results from this survey have been published extensively. The areas covered by these reports include: costs, financing and utilization; the need for a long term care AIDS strategy; the importance of coordinating hospital and community-based care for AIDS patients; the methodology for collecting AIDS information; and changing patterns in the treatment of AIDS patients. The analysis has also been used in developing legislative initiatives to address treatment needs created by HIV infection. The survey instrument has been translated into French and Dutch. NAPH member response to the survey has been consistently strong, approaching or exceeding 70% in each of the survey years.

Inpatient Care

The 67 NAPH member hospitals comprising the 1988 response group reported treating 9,495 AIDS inpatients, an average of 142 per hospital, representing 19% of persons with AIDS estimated to have been alive in 1988[7] (Table 5-1). Hospitals located in the Northeast averaged a greater number of patients, admissions and inpatient days than members in other areas of the country. On average, NAPH facilities in the Northeast treated 234 AIDS inpatients, more than double the number of cases treated in institutions in the South and West and six times more than members located in the Midwestern states (Table 5-2).

Overall average length of stay (LOS) for a single AIDS admission in 1988 was 17.7 days (ranging from a low of 10.9 in the West to a high of 24.2 days in the Northeast), while AIDS patients averaged 29.1 days per year in NAPH facilities. Patients in the Northeast averaged the greatest number of hospital days annually (40.4) and those in the South experienced the fewest (16.5 days). In the aggregate, AIDS patients treated in NAPH institutions were admitted an average of 1.6 times during 1988 (regional range: 1.5 in the South to 1.9 in the Midwest).

During the period 1985 through 1988, AIDS inpatient utilization more than doubled on several key variables. The average number of patients treated increased from 61 to 142, AIDS admissions rose from

Volunteer providing comfort to an AIDS patient at Goldwater Memorial Hospital in New York. *Photo by David Grossman*

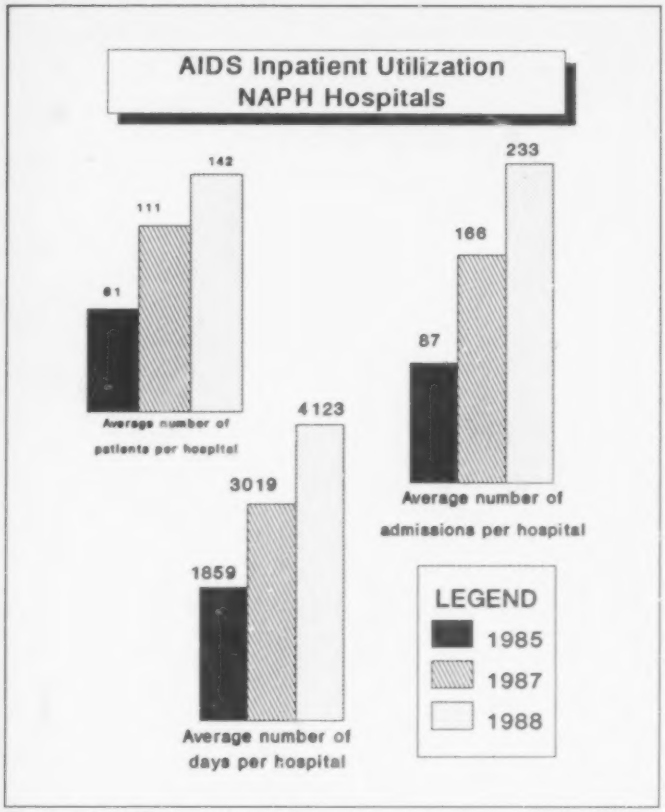


Figure 5-1 AIDS Inpatient Utilization

87 to 233 per hospital, and days multiplied from 1,859 to 4,123 (Figure 5-1). Regionally, the Northeast experienced the greatest absolute increase in average number of patients, admissions and days per hospital while NAPH members in the Midwest had the greatest percentage increases exceeding 200% for each of these variables.

Although hospitals experienced dramatic increases in AIDS inpatient caseloads from 1985 through 1988, some declines in individual patient utilization occurred. The average length of stay for an AIDS admission in NAPH facilities dropped more than four days from 21.3 to 17.7. With the exception of the Northeast, facilities in all geographic areas followed the overall trend toward reduced lengths of stay. LOS in the Northeast remains substantially higher than the rest of the country. Information from 1985 through 1988 strongly suggests that LOS in this region is following a pattern which is diverging significantly from other regions.

Average number of days per patient per year also declined, albeit not as sharply as length of stay, due to a slight increase in annual admissions per patient. In 1985, an AIDS inpatient treated in a NAPH facility averaged 30.6 hospital days and was admitted 1.4 times, while in 1988 the typical AIDS patient spent 29.1 days in the hospital but had 1.6 admissions.

Level of Care. Although some AIDS patients received treatment at the intensive care level (7% of inpatient days), the majority of care provided was acute hospital care, accounting for 82% of inpatient days (Table 5-3). Care rendered to patients who were medically ready for discharge, but for whom no appropriate discharge placement could be found, accounted for 10% of total inpatient days. Since not all hospitals routinely track medically ready for discharge days, the actual proportion of these days is undoubtedly higher. Regionally, hospitals in the West had the highest proportion of acute care days.

Discharge Disposition. About one-fourth (22%) of AIDS discharges in responding hospitals were deaths (Table 5-4). Hospitals indicated that for those patients discharged alive, return to home without formal assistance was the most common discharge status (70%). Discharges home with formal assistance occurred most often in the South (23%), more than double the overall percentage (9%).

Risk Group Characteristics. Together, the two largest risk group categories represented by AIDS patients treated in NAPH hospitals accounted for 80% of patients cared for in these facilities in 1988 (Table 5-5). Homosexuals comprised 46%, and heterosexual IV drug users 34%, of AIDS inpatients although considerable regional variation occurred. Hospitals in the Northeast, which had the lowest proportion of homosexuals (29%), treated the largest percentage of heterosexual IV drug users (53%). Conversely, three-fourths (74%) of patients cared for in the West were homosexuals while just 7% were heterosexual IV drug users.

Demographic Characteristics. Fully 90% of AIDS patients treated in NAPH facilities in 1988 were 20-49 years old with few geographic differences in age distribution. Hospitals in the South cared for the highest proportion of patients 0-2 years of age while

NAPH AIDS Inpatients as a Percent of Total AIDS Cases

Total AIDS Cases Estimated Alive During 1988	49,568
Total AIDS Inpatients Treated in NAPH Hospitals	9,495
NAPH as Percent of Total	19%

Table 5-1 NAPH AIDS Inpatients as a Percent of Total AIDS Cases—1988

AIDS Inpatient Utilization by Region in NAPH Hospitals 1985, 1987, 1988

	OVERALL			NORTHEAST			MIDWEST			SOUTH			WEST		
	1985	1987	1988	1985	1987	1988	1985	1987	1988	1985	1987	1988	1985	1987	1988
Patients															
Total	2,977	6,093	9,495	1,734	2,848	4,670	93	287	307	415	1,742	2,777	735	1,216	1,741
Average per hospital	61	111	142	116	178	234	12	29	38	52	134	121	41	76	109
Percent change		82	28		53	31		142	31		158	-10		85	43
Admissions															
Total	4,267	9,116	15,626	2,170	4,088	7,798	167	399	597	621	2,438	4,162	1,309	2,191	3,069
Average per hospital	87	166	233	145	256	390	21	40	75	78	188	181	73	137	192
Percent change		90	41		77	52		90	88		141	-4		88	40
Inpatient Days															
Total	91,094	166,036	276,220	58,174	97,181	188,741	2,559	5,758	8,147	10,549	33,531	45,796	19,812	29,566	33,536
Average per hospital	1,859	3,019	4,123	3,878	6,074	9,437	320	576	1,018	1,319	2,579	1,991	1,101	1,848	2,096
Percent change		62	36		57	55		80	77		96	-23		68	13
Average length of stay	21.3	18.2	17.7	26.8	23.8	24.2	15.3	14.4	13.6	17.0	13.8	11.0	15.1	13.5	10.9
Percent change		-15	-3		-11	2		-6	-5		-19	-20		-11	-19
Average number of days per patient per year	30.6	27.3	29.1	33.5	34.1	40.4	27.5	20.1	26.5	25.4	19.2	16.5	27.0	24.3	19.3
Percent change		-11	7		2	19		-27	32		-24	-14		-10	-21
Average number of admissions per patient per year	1.4	1.5	1.6	1.3	1.4	1.7	1.8	1.4	1.9	1.5	1.4	1.5	1.8	1.8	1.8
Percent change		4	10		8	19		-22	39		-7	7		0	0
Hospitals responding	49	55	67	15	16	20	8	10	8	8	13	23	18	16	16

Table 5-2 AIDS Inpatient Utilization by Region in NAPH Hospitals

Level of Care for AIDS Inpatients Overall & by Region – 1988

	Overall		Northeast		Midwest		South		West	
	N	%	N	%	N	%	N	%	N	%
Level of Care:										
ICU days	15,619	7	11,347	8	106	6	2,898	8	1,268	4
Acute care days	179,456	82	115,428	78	1,304	81	33,707	87	29,017	94
Medically ready for discharge – Adult	21,378	10	18,625	13	203	13	1,914	5	636	2
Medically ready for discharge – Children	240	0	221	0	0	0	19	0	0	0
Other	1,115	1	1,102	1	0	0	0	0	13	0
Total Days	217,608	100	146,723	100	1,613	100	38,538	100	30,934	100

Table 5-3 Level of Care for AIDS Inpatients

those in the West saw the greatest percentage of individuals 50 years or older (8%).

Not surprisingly, the overwhelming majority of AIDS patients were male (85%), with the greatest proportion of males (96%) treated in Western hospitals. NAPH members in the Northeast cared for the largest percentage of women (21%).

Slightly less than two-thirds of AIDS patients were minorities with blacks accounting for 39% and Hispanics 22% of individuals treated in NAPH institutions. Caucasians represented 37% of patients. Race group composition varied considerably by geographic area. The largest percentage of caucasians was in the West while hospitals in the Northeast and Midwest provided care to high percentages of blacks (49% and 50%, respectively).

Inpatient Financial Characteristics.

Source of Payment. Medicaid was the primary source of payment for AIDS inpatients accounting for more than half (56%) of AIDS admissions in NAPH facilities in 1988 (Table 5-6). The selfpay and other category, representing one-fourth (27%) of admissions, can be further subdivided into three distinct payment groups: selfpay (16%); special funding for AIDS patients (6%); and other (5%). Of these, selfpay

AIDS Discharges: Overall & by Region
NAPH Hospitals – 1988

	Overal		Northeast		Midwest		South		West	
	N	%	N	%	N	%	N	%	N	%
Total Discharges	12,770		6,212		389		3,661		2,508	
Deaths	2,752	22	1,302	21	85	22	965	26	400	16
Discharged Alive	10,018	78	4,910	79	304	78	2,696	74	2,108	84
	N	%*	N	%*	N	%*	N	%*	N	%*
Home – No Assistance	7,024	70	3,733	76	222	73	1,470	54	1,599	76
Home – With Assistance	896	9	71	1	50	16	627	23	148	7
Long Term Care Facility	375	4	81	2	8	3	177	6	109	5
Acute Care Facility	81	1	62	1	3	1	15	1	1	0
Prison	299	3	270	6	13	4	14	1	2	0
Other	1,343	13	693	14	8	3	393	15	249	12

* Percent of patients discharged alive

Table 5-4 AIDS Discharges Overall and by Region

Demographic and Risk Group Characteristics of AIDS Patients – 1988

	Overall	Northeast	Midwest	South	West
Risk Group:					
Homosexual	46%	29%	65%	63%	74%
Homosexual/drug user	8%	5%	7%	9%	14%
Heterosexual/drug user	34%	53%	22%	13%	7%
Sex partner of risk–group member	6%	6%	4%	9%	3%
Child of risk–group member	4%	6%	0%	4%	0%
Blood product related	2%	1%	2%	2%	2%
Age (in years):					
0–2	2%	2%	0%	3%	1%
3–19	2%	2%	0%	2%	0%
20–49	90%	90%	97%	90%	91%
50+	6%	6%	3%	5%	8%
Sex:					
Male	85%	79%	92%	87%	96%
Female	15%	21%	8%	13%	4%
Race:					
Caucasian	37%	15%	38%	54%	61%
Black	39%	49%	50%	35%	20%
Hispanic	22%	34%	11%	10%	17%
Other	2%	2%	1%	1%	2%
Hospitals responding	61	18	7	22	14
Patients represented	3,166	581	114	1,496	975

Table 5-5 Demographic and Risk Group Characteristics of AIDS Patients

Payer Source for AIDS Inpatients – Overall & by Region in NAPH Hospitals – 1985, 1987, 1988

(by Percent)

	OVERALL			NORTHEAST			MIDWEST			SOUTH			WEST		
	1985	1987	1988	1985	1987	1988	1985	1987	1988	1985	1987	1988	1985	1987	1988
Payer Source:															
Medicare	1	2	3	1	2	3	5	0	1	2	1	4	2	3	4
Medicaid	62	54	56	69	72	70	57	53	44	16	18	25	60	62	66
Selfpay and other	25	33	27	18	13	10	13	34	25	74	68	61	26	27	23
Private insurance	8	9	11	6	9	13	23	11	27	6	11	9	11	8	7
Prisoner	4	2	3	6	4	4	1	2	3	2	2	1	1	0	0

Table 5-6 Payer Source for AIDS Inpatients Overall and by Region

and other represent predominately charity care. Thus, more than three-fourths (77%) of AIDS admissions in NAPH hospitals were for low income patients (Medicaid + selfpay + other). Private insurance was the primary payer for 11% of AIDS admissions and Medicare for just 3%.

Striking regional differences were evident in some payer source categories. Medicaid admissions were highest in the Northeast (70%) and West (66%) and lowest in the South (25%) (Figure 5-2). In contrast, the South had a higher proportion of selfpay and other comprised of 42% charity care and 19% special AIDS funding. The highest percentage of private insurance coverage occurred in the Midwest (27%) and the lowest in the West (7%).

With the exception of Medicaid, the distribution of admissions by payer source did not change significantly from 1985 through 1988. Overall, the percentage of AIDS admissions for which Medicaid was the primary payer declined from 62% in 1985 to 54% in 1987 and then rose slightly to 56% in 1988, although two regions reported an increase in Medicaid patients during this period (Figure 5-3). Public hospitals in the South experienced the most notable growth in Medicaid admissions, accompanied by a decrease in selfpay/other people with AIDS. Other shifts in payer during the three year period were minor and may be attributable to differences in hospital response rates across years rather than actual payer shifts.

Cost, Charge, and Revenue. Slightly less than half of responding hospitals (representing 4,365 AIDS admissions) were able to provide inpatient financial information. The average daily cost to provide care to an AIDS patient was $779 in responding hospitals, yet these facilities collected $502 in revenue for a daily loss of $277 (Figure 5-4). Charges, at $962 per day, were 1.2 times higher than daily costs. Although the

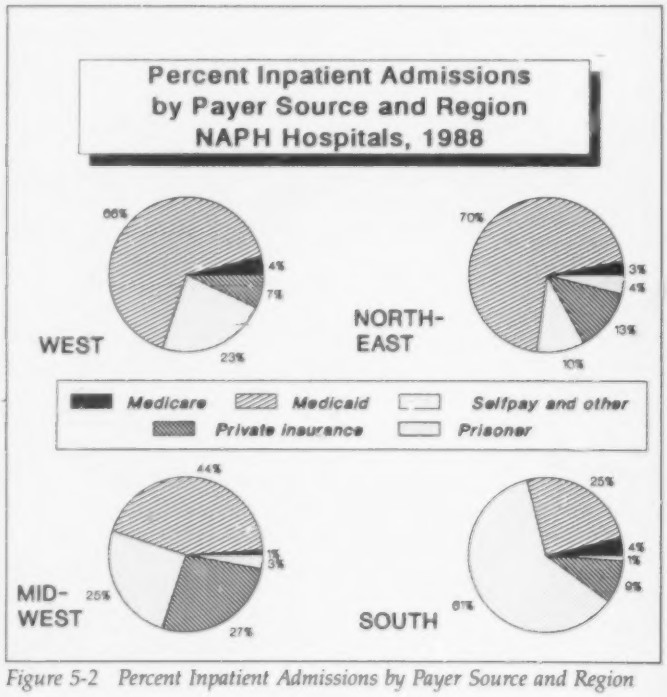


Figure 5-2 Percent Inpatient Admissions by Payer Source and Region

difference in cost per day for AIDS patients as compared with other medical/surgical cases was less than $50, hospitals incurred daily losses for AIDS patients that were almost $100 higher than losses for other medical/surgical patients ($185).

To estimate the annual costs to NAPH members for providing inpatient hospital care to AIDS patients, we applied annual utilization figures to daily costs ($779 average cost per day × 29.1 average number of days per patient per year) to arrive at a total annual cost of $22,061 per patient per year (Table 5-7). Annual

Inpatient Costs, Charges, and Revenues for AIDS and Other Medical/Surgical Patients
NAPH Hospitals – 1988

AIDS INPATIENTS: *	
Cost per day	$779
Cost per admission	$13,788
Cost per patient per year	$22,061
Charge per day	$962
Charge per admission	$17,027
Charge per patient per year	$27,244
Revenue per day	$502
Revenue per admission	$8,885
Revenue per patient per year	$14,217
Loss per day	$277
Loss per admission	$4,903
Loss per patient per year	$7,845
OTHER MEDICAL/SURGICAL INPATIENTS: **	
Cost per day	$732
Charge per day	$928
Revenue per day	$547
Loss per day	$185

* Based upon 27 hospitals and 4,365 admissions.
** Based upon 22 hospitals and 3,998 admissions.

Table 5-7 Inpatient Costs, Charges, and Revenues for AIDS and Other Medical Surgical Patients

revenues were $14,217 per patient resulting in losses of almost $8,000 per patient per year.

Outpatient Care

Not all NAPH members have the ability to track AIDS outpatients, while even fewer can provide financial information for these patients. The small number of responses to questions about outpatient utilization and financing makes interpretation of the data difficult. We have included outpatient figures in this report to provide the reader with a broader understanding of the magnitude of AIDS care furnished in NAPH hospitals. Forty-two percent of responding hospitals provided information on care provided to AIDS outpatients. As a group, these hospitals treated 6,604 outpatients in 1988 with a total of 46,909 visits (Table 5-8). On average, hospitals treated 236 AIDS outpatients and provided more than 1,600 visits. The average AIDS outpatient in responding facilities had slightly more than 7 visits per year.

Unlike the inpatient setting where Medicaid was the payer for the majority of admissions, more than half of all outpatient visits were selfpay and other. Just 6% represented special funding for AIDS patients while 47% was predominately charity care (Figure 5-5). Somewhat more than one-third (37%) of visits were covered by Medicaid while the proportion of visits covered by Medicare and Private Insurance, at 3% and 7%, respectively, were similar to inpatient payment patterns.

Approximately one-third of NAPH facilities that furnished outpatient utilization figures also provided cost, charge, and revenue for these patients. However, the small group of hospitals with the ability to track this information accounted for 81% of reported visits. The average cost for a single outpatient visit, $342,

was less than half of that for one day of inpatient care. Outpatient reimbursement, as a percentage of cost, lagged far behind payment for inpatient care. Hospitals reported average revenues per visit of $99, or 29% of the cost of providing treatment. Conversely, daily revenue per inpatient, as a percentage of cost, averaged 64%. Calculated losses per visit (average cost minus average revenue) were $243 for an annual loss of $1,725 per outpatient.

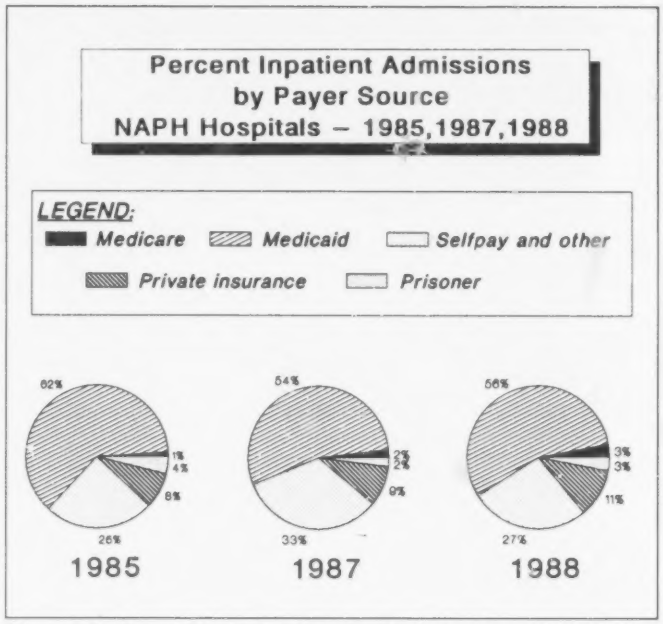


Figure 5-3 Percent Inpatient Admissions by Payer Source, 1985, 1987 and 1988

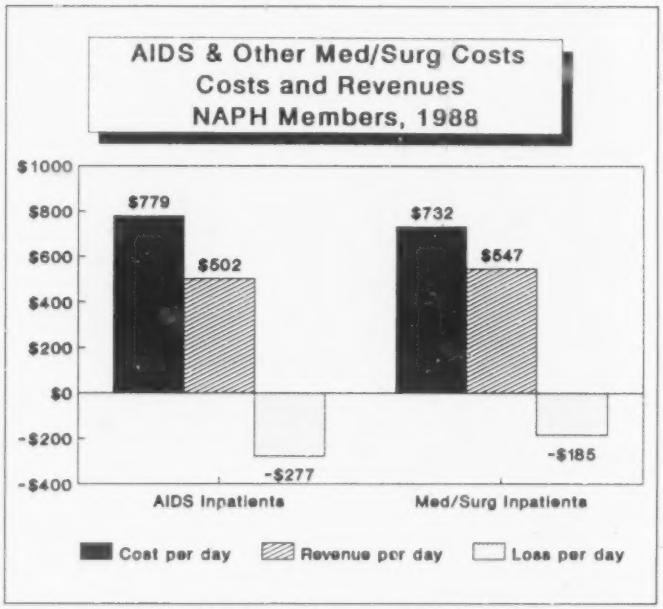


Figure 5-4 AIDS and Other Med/Surg Costs and Revenues

Hospital Organization, Training, and Special Services

As AIDS caseloads in NAPH hospitals continue to grow, many member facilities have instituted formalized policies to handle issues related to caring for AIDS patients. Two-thirds or more of responding institutions reported that they had established written policies to deal with treatment of AIDS patients (67%), hospital employees who had AIDS or were HIV positive (70%), and with confidentiality issues for AIDS patients (75%) (Figure 5-6). Not surprisingly, regional variation in the proportion of hospitals with written policies was directly related to caseload size. Greater numbers of hospitals in the Northeast, where caseloads were highest, had policies in place than in any other region. NAPH members in the Midwest treated the fewest AIDS patients and were also the least likely to have formal written policies.

Hospitals have devised varying organizational, training and treatment strategies to facilitate efforts to provide an optimal level of care to AIDS patients. Although AIDS patients are often placed in available beds in infectious disease units or other areas of the hospital, a few responding hospitals indicated that they operate discrete AIDS units. For those hospitals operating separate units by the end of 1988, the average size of these units was 23 beds (Table 5-9). Case management techniques were used by somewhat more than half (57%) of responding hospitals, with almost all facilities located in the Northeast indicating that they utilized case management.

Most hospitals conduct staff and community education programs on AIDS. More NAPH members reported that they provided special AIDS training programs to ancillary and support staff (87%) than to staff working directly with AIDS patients (73%).

NAPH members indicated that they provide diverse services to AIDS patients, to assist them in coping with the illness and to facilitate ongoing treatment after discharge. Individual counseling was by far the most frequent service offered, overall (69%) and among regions (Figure 5-7). About half of all hospitals provided worship or prayer services and a similar proportion made bereavement and self-help services available. Group counseling was the service provided least frequently (24%) with not more than 40% of NAPH members in any geographic area offering such support.

Although hospitals indicated that they offer AIDS patients a variety of support services internally, many also reported taking advantage of already existing community support groups representing various populations at risk for AIDS. Overall, about two-thirds

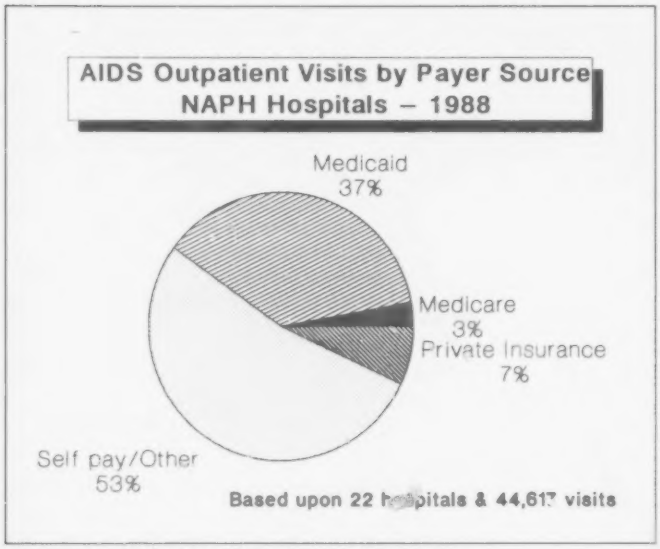


Figure 5-5 AIDS Outpatient Visits by Payer Source

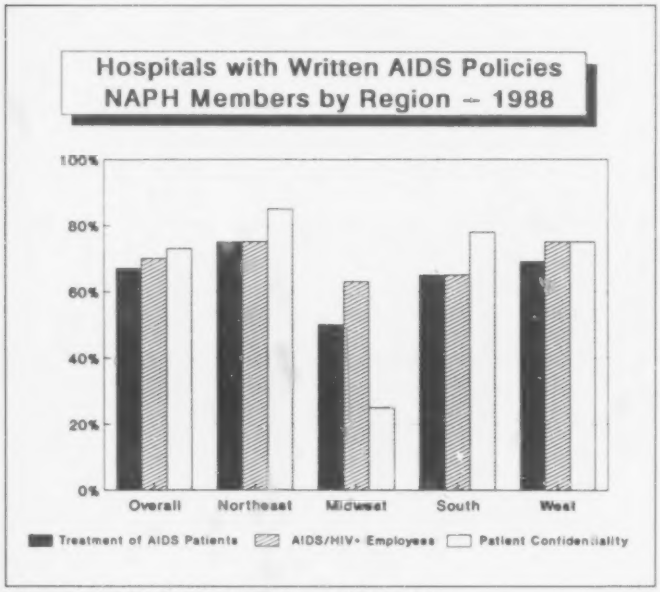


Figure 5-6 Hospitals with Written AIDS Policies

of hospitals had established formal links with community support groups representing homosexuals, drug users, minorities, and women at risk (Figure 5-8). NAPH members located in the Northeast, which treated the highest proportion of heterosexual IV drug using AIDS patients, were most likely to have formal links with groups representing drug users.

Treatment of "Other HIV" Patients

The substantial number of AIDS patients treated in NAPH member hospitals clearly has a considerable impact, financial and otherwise, on these institutions. However, the burden of caring for patients who have been diagnosed as meeting the CDC definition of AIDS represents only a portion of the total load of treating individuals with AIDS and other HIV related illness. Although the effects of caring for patients with other HIV-related illness also pose serious problems to NAPH members, accurate data on "other HIV" patients have been difficult to obtain. Institutional tracking systems are frequently designed to monitor only AIDS cases or are unable to distinguish between AIDS and "other HIV" patients providing information in the aggregate only. However, for 1988 three-fourths of responding NAPH members had the capacity to furnish figures on individuals with other HIV-related illness. Except as noted otherwise, the findings described in the following sections are based upon this set of 52 hospitals.

Inpatient Utilization. Responding NAPH hospitals reported treating 5,664 inpatients with HIV-related illness, averaging 109 patients per hospital. These hospitals treated 138 AIDS inpatients, on average, during the same period (Table 5-10). As a group, these individuals had 7,112 admissions and accounted for 120,978 hospital days. On average, individuals with other HIV illness had 1.3 inpatient admissions in 1988 and each admission lasted 17 days. As expected, due to the greater severity of their condition, AIDS patients in these institutions had higher levels of inpatient utilization than "other HIV" patients, although differences were not substantial. AIDS patients' hospital stays, at 18.2 days, and the number of admissions per patient per year, 1.7, were higher. The most notable difference in utilization between AIDS and "other HIV" patients, due to the combined effects of longer lengths of stay and higher annual admissions, was average number of days per patient per year. AIDS patients averaged total annual stays that were 44% higher than for "other HIV" patients (30.8 versus 21.4).

The added burden to hospitals of caring for individuals with other HIV illness is evident in the collective utilization figures for both AIDS and "other HIV". In the aggregate, responding NAPH hospitals treated a total of 12,854 inpatients in both groups representing 342,246 days. Individuals with HIV related conditions accounted for 44% of the total patient caseloads and 35% of days. For every five persons with AIDS receiving care in NAPH hospitals, there were 4 other patients with HIV-related illness who also required inpatient medical care.

Outpatient Utilization. A small group of hospitals was able to supply outpatient utilization data for both AIDS and "other HIV" patients. Eighteen NAPH members indicated that they provided outpatient care to over 3,000 "other HIV" patients, averaging 173 outpatients and 745 visits per facility (Table 5-11). Typically, "other HIV" patients had 4.3 outpatient

AIDS Outpatient Utilization and Finances
NAPH Hospitals – 1988

AIDS OUTPATIENT UTILIZATION: *

Outpatients	
Total	6,604
Average per hospital	236
Visits	
Total	46,909
Average per hospital	1,675
Average number of visits per patient per year	7.1

AIDS OUTPATIENT FINANCIAL INFORMATION: **

Cost per visit	$342
Cost per patient per year	$2,428
Charge per visit	$383
Charge per patient per year	$2,719
Revenue per visit	$99
Revenue per patient per year	$703
Loss per visit	$243
Loss per patient per year	$1,725

* Based upon 28 hospitals.
** Based upon 10 hospitals with 37,915 visits

Table 5-8 AIDS Outpatient Utilization and Finances

Hospital Organization and AIDS Education Programs
NAPH Hospitals – 1988

	Overall		Northeast		Midwest		South		West	
	N	%	N	%	N	%	N	%	N	%
Operate Discrete AIDS Unit	8	12%	4	20%	0	0%	3	13%	1	6%
Average Number of Beds	23		21		0		26		20	
Utilize Case Management	38	57%	19	95%	5	63%	7	30%	7	44%
Provide AIDS Training and/or Education Programs for:										
Staff working directly with AIDS patients	49	73%	16	80%	5	63%	17	74%	11	69%
Staff not working directly with AIDS patients	55	82%	18	90%	7	88%	19	83%	11	69%
Ancillary and support staff	58	87%	20	100%	7	88%	20	87%	11	69%
Provide AIDS Education Programs to Community	50	75%	19	95%	7	88%	16	70%	8	50%

Table 5-9 Hospital Organization and AIDS Education Programs

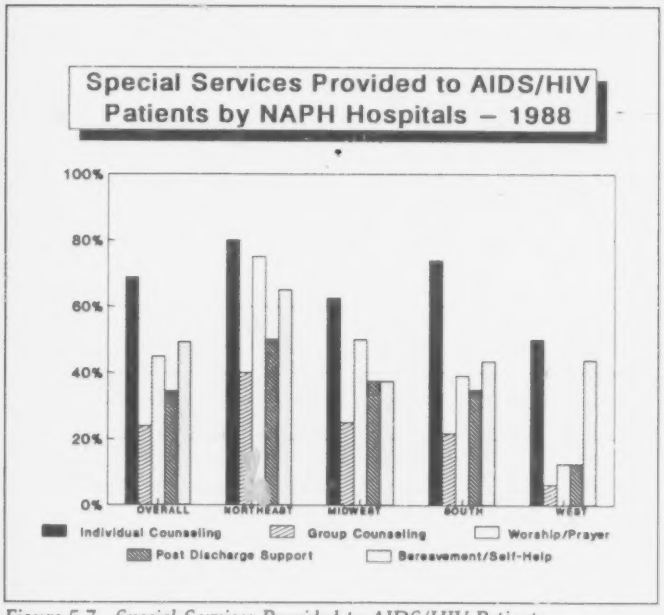


Figure 5-7 Special Services Provided to AIDS/HIV Patients

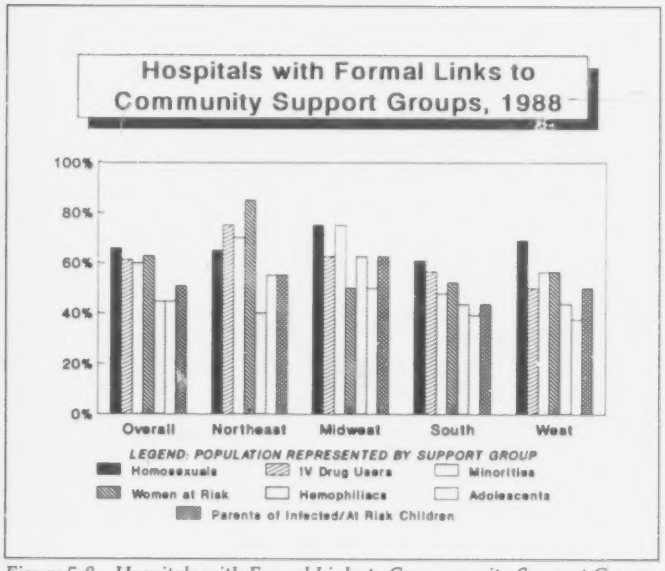


Figure 5-8 Hospitals with Formal Links to Commmunity Support Groups

visits annually, as compared to 6.0 visits for AIDS patients in these hospitals.

Level of Care and Discharge Disposition. "Other HIV" patients received inpatient treatment at a similar level of intensity as AIDS patients in the overall response group with acute care days comprising 83% of all inpatient days. Although intensive care utilization was marginally higher for persons with other HIV related illness than for those with AIDS (10% versus 7%), the variation is too small to suggest any substantive differences.

As with AIDS patients, upon discharge persons with other HIV illness usually returned home without formal arrangements for assistance (76%) (Table 5-12). "Other HIV" admissions were less likely to end in death (9%) than AIDS admissions (22%).

Risk Group Characteristics. To allow for accurate comparisons of risk group composition, we examined the subset of responding hospitals that had provided information for both AIDS and "other HIV" patients. The resulting set of hospitals reported that the proportion of heterosexual IV drug users was considerably higher for individuals with other HIV conditions (60%) than for AIDS patients (42%) (Figure 5-9). Although one might posit that IV drug users, because of their marginal status within society, may not enter the health care system until their health has severely deteriorated, this does not appear to be the case in NAPH hospitals. Alternatively, homosexuals with HIV-related conditions are probably better insured than IV drug users and may turn first to private institutions for treatment, utilizing public hospitals later in their illness, when their insurance runs out.

Demographic Characteristics. Persons with other HIV illness treated in NAPH facilities were somewhat more likely to be female (26%) and black (49%) than AIDS patients treated in these institutions (Table 5-13). In view of the higher proportion of IV drug users among individuals with other HIV conditions, this finding is not unexpected.

Inpatient and Outpatient Financial Characteristics.

Source of Payment. Payment for medical care provided to individuals with other HIV illness resembled reimbursement patterns for AIDS patients, with some minor exceptions. Fifty-eight percent of "other HIV" inpatient admissions were reimbursed by Medicaid while selfpay and other represented 30% (Figure 5-10). Private insurance coverage, representing 6% of "other HIV" admissions, was lower than for AIDS patients.

Paralleling payer source findings for AIDS outpatient care, Medicaid represented a much lower proportion (29%) and selfpay/other a higher percentage (56%) of "other HIV" outpatient visits than inpatient admissions (Figure 5-11). Special funds for HIV, a subset of the selfpay and other category, comprised 8% of total outpatient visits.

Cost, Charge and Revenue. A subset of 20 NAPH member facilities representing 3,689 AIDS and 1,944 HIV related admissions reported financial information for both illness categories. At $656 per day, hospitals reported average costs to treat "other HIV" patients were 84% of costs for AIDS patients (Table 5-14). Average daily revenues for "other HIV" patients were 57% of costs ($375) resulting in a loss per day ($281)

Inpatient Utilization for AIDS and Other HIV Patients
NAPH Hospitals – 1988

	AIDS	Other HIV
Patients:*		
Total	7,190	5,664
Average per hospital	138	109
Admissions:*		
Total	12,182	7,112
Average per hospital	234	137
Inpatient Days:*		
Total	221,268	120,978
Average per hospital	4,255	2,327
Average length of stay	18.2	17.0
Average number of days per patient per year	30.8	21.4
Average number of admissions per patient per year	1.7	1.3

* As reported by 52 hospitals.

Table 5-10 Inpatient Utilization for AIDS and Other HIV Patients

that was slightly higher than for AIDS patients. Despite the marginally higher daily losses for "other HIV", annual inpatient losses for these patients averaged $2,500 less than for AIDS patients due to lower utilization levels.

With more than half of the total AIDS/HIV inpatient population reliant upon Medicaid to finance their hospital stays, and a large number of patients lacking insurance, NAPH members serve a sizable portion of

Discussion

Research findings from the U.S. Hospital AIDS Survey for the period 1985-88 demonstrate that NAPH hospitals have shouldered an enormous increase in the provision of health care services to AIDS patients. They also serve as significant providers of treatment to individuals with other HIV-related illness. Despite their somewhat lower utilization, considerable hospital resources are directed toward caring for "other HIV" patients. In fact, the results from NAPH members strongly indicate that "other HIV" patients may not need to be admitted for inpatient care as frequently as AIDS patients, but once they become sufficiently ill and require hospitalization, their stay is similar to those diagnosed with AIDS. An accurate assessment of the impact of the AIDS epidemic on NAPH facilities must include the total burden of AIDS and HIV care.

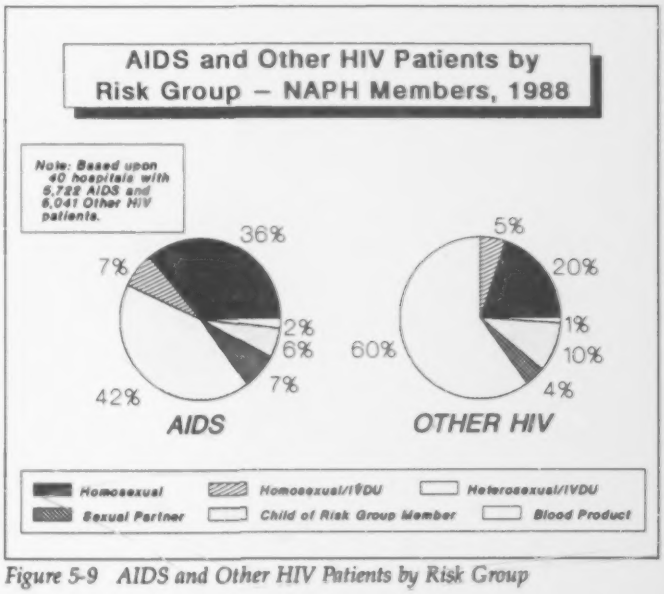


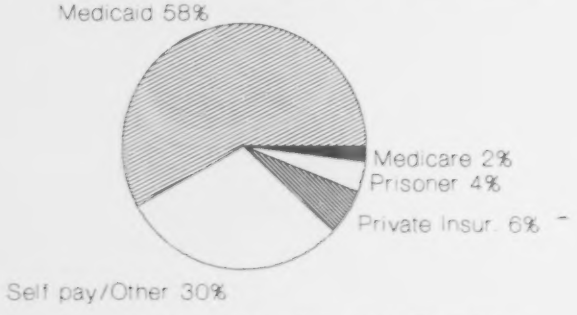
Figure 5-9 AIDS and Other HIV Patients by Risk Group

AIDS and Other HIV Outpatient Utilization
NAPH Hospitals – 1988

	AIDS	Other HIV
Outpatients:		
Total	3,541	3,113
Average per hospital	197	173
Outpatient visits:		
Total	21,314	13,406
Average per hospital	1,184	745
Average number of visits per outpatient	6.0	4.3
Responding hospitals	18	18

Table 5-11 AIDS and Other HIV Outpatient Utilization

Other HIV Inpatient Admissions by Payer Source – NAPH Members, 1988



Based upon 47 hospitals and 6,837 admissions

Figure 5-10 Other HIV Inpatient Admissions by Payer Source

Other HIV Discharges
NAPH Hospitals – 1988

	N	%
Total Discharges	6,452	
Deaths	604	9%
Discharged Alive	5,848	91%
	N	**%***
Home–No Assistance	4,428	76%
Home–With Assistance	174	3%
Long Term Care Facility	142	2%
Acute Care Facility	61	1%
Prison	240	4%
Other	803	14%

* Percent of patients discharged alive

Table 5-12 Other HIV Discharges

impoverished persons with AIDS and HIV. For outpatient services, the safety net role of NAPH hospitals is even more apparent where as many as half of all visits are charity care.

Survey results indicate that AIDS and "other HIV" patients represent a severe drain on hospitals' financial resources. The annual losses to hospitals are even more staggering, with no respite in sight if AIDS caseloads continue to increase and no additional sources of financing treatment are created.

The decrease in average length of stay for a hospital admission is probably due to several factors, including an increased tendency toward providing care on an outpatient basis, and concerted efforts to coordinate with existing community services in the provision of post-discharge support. Unfortunately, current reimbursement patterns favor treatment in the inpatient setting, and do not encourage use of outpatient services, in spite of their cost-saving potential. Moreover, the sheer lack of alternate settings for difficult to place patients may increase inpatient utilization, as it has among Northeastern institutions.

As NAPH hospitals face the second decade of the AIDS epidemic, many of them have developed

innovative approaches and comprehensive service systems to care for the medical and psycho-social needs of patients with AIDS and other HIV illness. Public hospitals have a long history of "making do" with scare resources. Yet without supportive policy and reimbursement decisions that cover the full spectrum of HIV conditions, these and similar hospitals will find their ability to meet the needs of these individuals and others who comprise the safety net population dangerously compromised.

Meeting the Challenge—Public Hospital Models of Care

Safety net hospitals have been involved in caring for persons with AIDS since the epidemic began, and continue to provide a disproportionate share of the health care services persons with AIDS require. As the epidemic expands, and caseloads grow, NAPH member hospitals continue to see larger and larger numbers of patients, more and more of whom are uninsured or underinsured. The combination of growth in the HIV epidemic with other urban problems of drugs, violence, poverty, homelessness, and mental illness present public hospitals with unprecedented challenges—challenges that have been met with creativity, compassion, and dedication.

In order to document the diverse models that have evolved in public hospital HIV programs, NAPH's AIDS Committee sent representatives to visit 18 metropolitan area hospitals tour the HIV program and meet with key staff. These visits provided a wealth of information on the structure of AIDS/HIV care in public hospitals, the problems faced by hospitals in setting up programs, and the types of programs that were most successful for different populations.

A common thread running through all of the AIDS programs visited was the importance of having a continuum of care available in the community, and the importance of maintaining ties to community-based providers. Each of the hospitals visited has formed links with other agencies in the community. Nearly all hospitals provide case management services to the HIV population, although definitions of case management vary considerably.

Apart from these similarities, the care models used in public hospitals vary considerably, depending on the patient population, and the community's resources—both financial and programmatic. There is consensus that the "San Francisco Model," however successful in San Francisco, cannot be duplicated in every city.

On the inpatient side, several hospitals currently provide a dedicated inpatient unit (5 out of 18).

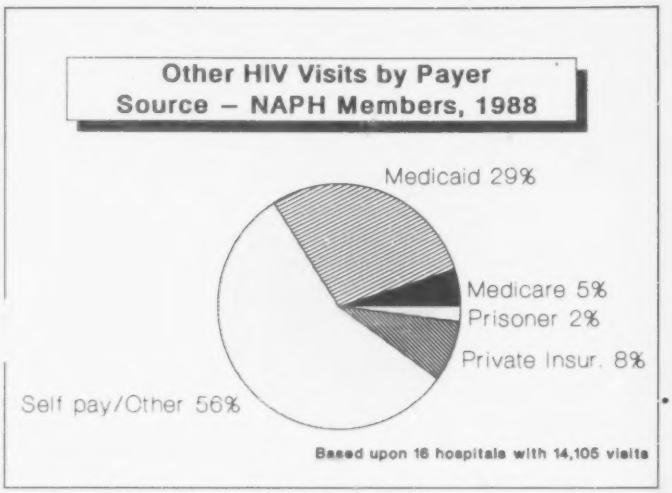

Other HIV Visits by Payer Source – NAPH Members, 1988
Medicaid 29%
Medicare 5%
Prisoner 2%
Private Insur. 8%
Self pay/Other 56%
Based upon 16 hospitals with 14,105 visits

Figure 5-11 Other HIV Visits by Payer Source

Demographic Characteristics of Other HIV Patients
NAPH Hospitals – 1988

Age (in years):	
0–2	5%
3–19	3%
20–49	87%
60+	5%
Sex:	
Male	74%
Female	26%
Race:	
White	22%
Black	49%
Hispanic	27%
Other	2%
Responding hospitals	46
Patients Represented	5,506

Table 5-13 Demographic Characteristics of Other HIV Patients

Generally, these hospitals tend to be hospitals with a large daily AIDS census, and the units tend to house only a portion of the total daily census. The majority of hospitals do not have such a unit, preferring to place persons with AIDS on medical units, or on other units depending upon the patients particular medical need.

Almost all hospitals provide outpatient services in a dedicated AIDS or Infectious Diseases Clinic. Hospitals

Inpatient Costs, Charges and Revenues Comparison of AIDS and Other HIV Patients
NAPH Hospitals – 1988

	AIDS *	Other HIV **
Cost per day	$780	$656
Cost per admission	$14,196	$11,152
Cost per patient per year	$24,024	$14,038
Charge per day	$961	$616
Charge per admission	$17,490	$10,472
Charge per patient per year	$29,598	$13,182
Revenue per day	$503	$375
Revenue per admission	$9,155	$6,375
Revenue per patient per year	$15,492	$8,025
Loss per day	$277	$281
Loss per admission	$5,041	$4,777
Loss per patient per year	$8,532	$6,013

* Based on 20 hospitals with 3,689 AIDS admissions. ** Based on 20 hospitals with 1,944 HIV–related admissions.

Table 5-14 Inpatient Costs, Charges, and Revenues—Comparison of AIDS and Other HIV Patients

report that having a dedicated clinic allows for a concentration of expertise, as well as more consistent follow-up of patients. The structure and focus of these clinics, however, differed across hospitals. In many cases, hospitals utilized a primary care model, with the clinic serving as the center of care coordination for the patients. In other hospitals, specialty clinics, staffed with infectious disease specialists provide services in conjunction with a patient's primary care provider, often located in the hospital's general outpatient clinic.

Each of the hospitals visited has structured services around the specific needs of their patients, within the resource limitations that always impact on service provision in public hospitals. The hospitals reported a constant self-examination, and frequent changes and additions to the service package to keep pace with the rapidly changing AIDS epidemic. In each case, AIDS staff reported a chronic under-funding of services, but also a general satisfaction with the success of the model they had developed. As the AIDS epidemic progresses, the systems of care developed in public hospitals may serve as a guide for other hospitals in setting up HIV programs. A report detailing the models of care used by NAPH hospitals will be released in early 1991.

[7]The estimate of the number of persons with AIDS estimated to be alive during a given year is based upon communication with Meade Morgan, Centers for Disease Control, December 18, 1988.

Drugs

Drug Abuse in the Nation's Cities

Drug use has become epidemic in our nation's cities, contributing to increased crime and violence, as well as to increased public health problems. The sharing of "works", the apparatus used to administer intravenous drugs, spreads diseases such as AIDS and hepatitis. The drug abuse lifestyle, coupled with the debilitating effects of drugs themselves, are causing severe health problems for users. Violence associated with drug and alcohol use filters out to the community as a whole. The availability of new, inexpensive drugs such as crack has brought drugs into the hands of more people, and has contributed to the current drug crisis hitting American cities. Public hospitals, traditionally the providers of care to many groups of the medically disenfranchised, are also the chief providers of care to the inner city drug using population and feel most acutely the far-reaching effects drug use has on the community.

The true impact of drug use on health care providers is difficult to measure. Frequently, drug use is secondary to trauma or other medical complaints, and it is not always carefully documented in medical records, making patient tracking difficult. Testing all patients for drug use is an expensive, and potentially problematic, endeavor. Many hospitals, however, do attempt to monitor the extent of the drug problem by checking for primary and secondary diagnoses that are related to drug use. In NAPH hospitals in 1988, hospitals reported an average of 4,583 ED visits where the primary diagnosis was drug-related, and an average of 14,066 ED visits with a drug-related secondary diagnosis. In total, hospitals reported more than 18,000 ED visits per year related to substance abuse, or 29% of all ED visits (See Table 6-1).

Drugs and Public Hospital Services
15 NAPH Hospitals – 1988

ED Visits with:	Average per hospital
Primary Diagnosis Drug–Related	4,583
Secondary Diagnosis Drug–Related	14,066
Total Drug–involved ED Visits	18,649

- This represents **29%** of the ED Visits for these hospitals.

Table 6-1 Drugs and Public Hospital Service

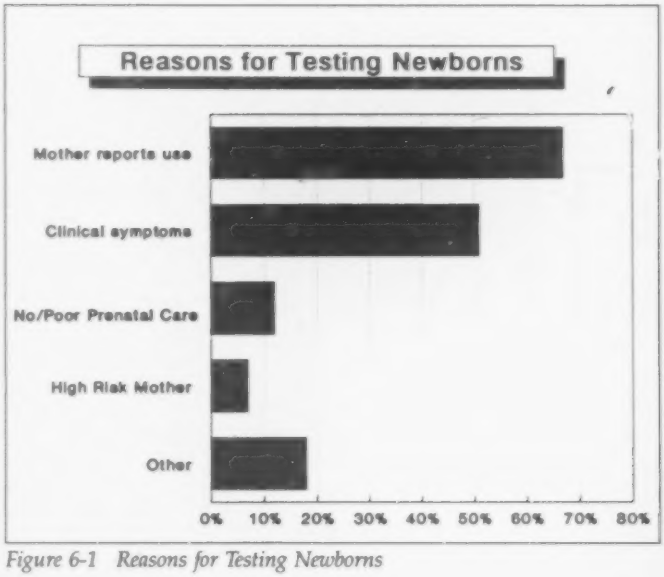


Figure 6-1 Reasons for Testing Newborns

For many safety net hospitals, however, drug use has an even greater impact on the hospital. At Harbor-UCLA Medical Center in Los Angeles, for example, an evaluation of the emergency department patient population on Saturday night September 22, 1990, revealed that 67% of the patients were being evaluated for the acute or chronic effects of drug or alcohol use.[8]

Cocaine-Involved Newborns

As the drug epidemic rages in our nation's cities, hospitals are reporting increasing demands for drug-related medical care. The availability of "crack," a smokable form of cocaine, has made illicit drugs more accessible for more people. As a result, more people, including women of child-bearing age are becoming involved in the use of drugs, and we are seeing an alarming increase in the number of newborns affected by prenatal drug use.

Safety net hospitals, operating in metropolitan areas and treating a substantial volume of patients who are poor, often also see a large volume of drug-related patients, including neonates who are cocaine-involved. The implications of the growing number of children born to drug-abusing mothers are substantial. There is evidence that drug-exposed children have higher hospital costs[9], and present with a variety of physical and developmental impairments which may result in increased health and social service costs throughout the child's lifetime. Many of these costs will be borne by the public health, hospital, and social welfare systems.

Cocaine–Exposed Infants
NAPH Hospitals – 1988

	1988 12 Months	1989 (1st 6 Months)	Percent Increase
Total	2693	1817	
Average per hospital	104	61	17%
Hospitals reporting	26	30	

Table 6-2 Cocaine-Exposed Infants

Emergency departments are the primary port-of-entry for blunt and penetrating trauma. Many of these patients' injuries are exacerbated by their indulgence in drugs and alcohol.

- A code yellow (emergency trauma) patient was brought in by paramedics after being involved in an auto versus street pole accident. He presented in the Emergency Department with multiple lacerations to the head with possible cranial injuries. Cervical-spine precautions were administered, however, the patient was non-responsive to verbal and tactual stimuli. The patient had ETOH (alcohol) on his breath upon arrival. He was worked-up by the surgical team and routine bloods were drawn and sent to the laboratory. CAT-scans were taken and the lacerations were sutured. The initial intervention was predicated on the assumption that the patient had incurred cranial injuries. Following the physical examination by the physician which proved negative, the x-rays and CAT-scan were also found to be negative. Only after several hours of treatment was it known through the serum toxicology test that the patient was non-responsive due to an ETOH level of 500 mg. percent. The patient was subsequently discharged following observation.

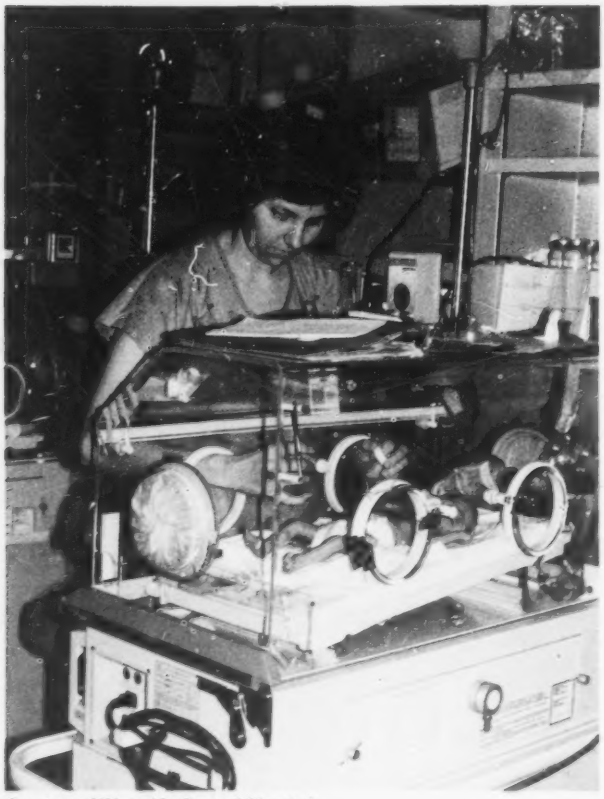
- A fourteen year old patient came in to the Emergency Department via ambulance following a neighborhood shooting in which he was shot in the back. The patient was wildly combative with an indication of PCP intoxication and ETOH abuse according to the police report. Patient was told to lie still numerous times and was placed in C-spine precautions. The patient persisted and eventually jumped off the bed leaving him paralyzed from the waist down.

Often the crises in emergency departments result from the treatment of the victims of drug-related crimes and violence rather than the drug-users.

- A 20 year old woman was sent to the hospital via ambulance after having been abducted at gun point, gang-raped, shot while attempting to escape, and dumped at 99th Street and Figueroa in Los Angeles. The perpetrators were believed to have been using illegal drugs at the time of the attack. The patient examination revealed a gun shot wound to the neck and the base of the mid-occipital skull. CAT-scan showed the bullet to have traversed the back of the head and was now lodged in the right lateral ventricle. The patient underwent surgery and hospital admission.

- An eight-month pregnant woman arrived in the Emergency Department as the victim of an auto accident with a driver who was intoxicated. An extensive evaluation of the patient was carried out to rule-out internal injuries as well as skeletal damage. Skull, chest, and spinal x-rays and extensive laboratory work were performed. Surgical, obstetrical, and radiological consultations were obtained. The patient was transferred to Labor and Delivery (L&D) after assessing the fetal heart-tones. Upon arrival in L&D further study indicated that the fetal heart-tones and fetal motion had ceased. Labor was induced only to find 40% abruptio (rupture) of placenta and the fetal demise was confirmed.

Provided by Los Angeles County Martin Luther King Jr./Drew Medical Center.



Courtesy of Riverside General Hospital

The increasing concern among public hospital staff members about this problem prompted a survey of NAPH member hospitals. The survey was patterned after a survey of social work departments that was conducted by the Family Studies Center of the University of Missouri, Kansas City. Only 21% of the NAPH hospitals reported that they routinely screen newborns for drug exposure. The majority of hospitals reported that newborns are tested when the mother reports drug use (67%) or when specific clinical symptoms appear in the infant (51%). Twelve percent (12%) reported that infants were tested when there was no or poor prenatal care (See Figure 6-1).

Hospitals reported an average of 104 cocaine-exposed newborns during 1988 and an average of 61 during the first half of 1989, illustrating an annual increase of about 17% (See Table 6-2). In most cases, however, testing of infant urine only detects cocaine use during the 60 hours prior to delivery. Drug use prior to that would not be detected. For this reason, the true number of infants exposed to drugs during pregnancy is much higher than can be measured by testing the infant. Hospitals reported an average length of stay for these newborns of 7.8 days, much higher than for a routine birth. In addition, hospitals reported that 9.4% of these days were "administrative days," days for which the infant was medically cleared for discharge. This illustrates the additional social service needs and difficult discharge planning often association with these children.

A major obstacle to reduction in this problem is the lack of funds for adequate and properly designed treatment programs for women drug users. Seventy percent (70%) of hospitals reported that there was a wait of several weeks or more for drug treatment for pregnant women in their area. Seven percent (7%) reported a wait of up to a year, and 10% said no drug treatment programs were available for pregnant women. For the most part, drug treatment programs do not make accommodations for children, making access to these programs difficult or impossible for many women.

As with the drug epidemic in general, drug use in women will only be reduced by a concerted effort on the part of law enforcement and treatment providers, backed by necessary resources to create treatment options that are accessible and available to those who seek treatment.

- **Memorial Medical Center**, Savannah, GA, reported 17 cocaine-involved infants in 1988 and 18 in the first half of 1989.
- **D.C. General Hospital** reported that 20% of newborns in 1988 and 1989 tested positive for illicit drugs.
- Los Angeles County's **King-Drew Medical Center** reported 600 cocaine-exposed infants in 1988, and 325 in the first half of 1989. Average length of stay was 5 days, and the hospital reported 975 days were "administrative days".
- **Truman Medical Center** in Kansas City Missouri, reported that 15% of all infants born in an eight week period tested positive for Cocaine exposure.
- **Riverside General Hospital**, in Riverside California reported 21 cocaine-exposed newborns in 1988, and in the first half of 1989, 58 newborns were identified as being cocaine-exposed.
- **Maricopa County Medical Center** in Phoenix reported 72 cocaine-involved infants in 1988 and 44 in the first six months of 1989.

[8]Memorandum to Ed Foley, LA County Harbor UCLA Medical Center, September 25, 1990.

[9]*Drug-Exposed Infants: A Generation at Risk* Report to the Chairman, Committee on Finance, U.S. Senate June, 1990 P.27.

7

Alternate Level of Care and Patient Outplacement

The Alternate Level of Care (ALC) patient has been a concern to hospitals, regulators, health planners, and community leaders since the mid-70s. ALC patients are those patients who, as determined by their physician, no longer need acute medical services, but require a continuation of care at a lower level (i.e., placement in a skilled nursing facility, residential care facility, home health program, etc.) that is unavailable, leaving the patient in the acute care setting. For public hospitals, the management of ALC days has impacted on medical education, caused access restrictions due to the inappropriate utilization of acute care beds, and resulted in severe reductions in hospital reimbursement. With demographics shifting toward an aging population, the ALC problem is likely to escalate, especially among the frail elderly. Many factors, including the decertification of acute care beds, insufficient long term care resources, and a lack of incentives for alternative support programs, have placed this societal problem squarely in the lap of the public hospital. These hospitals have become the institution of last resort for patients in need. Societal and health-related issues, such as substance abuse, mental illness, disruptive behavior, and homelessness, have all contributed to the growth in ALC patients.

NAPH Alternate Level of Care Survey

In an effort to assess the extent and impact of alternate level of care patients on NAPH hospitals, the association fielded a survey to its membership in December 1989. Forty-two NAPH facilities responded to the survey with more than half (57%) reporting the ability to track ALC days. Failure to monitor ALC days did not necessarily indicate a marginal impact of ALC patients on member hospitals. One-third of hospitals without ongoing tracking systems noted that the management of ALC patients had adverse consequences for their institutions.

The survey requested hospitals to provide separate ALC information for infants less than one year of age and for all other inpatients (hereafter referred to as adult ALC patients). For the group of nineteen hospitals providing complete data on adults, facilities experienced a slight decrease in the number of ALC days from 1987 to 1989 but an increase in ALC patients. In 1987, NAPH hospitals averaged 410 patients representing 12,208 days (Table 7-1). In 1989, hospitals reported 446 patients representing 11,284 ALC days, although considerable variation among hospitals was evident. In 1989, the number of adult ALC patients in individual institutions ranged from 3 to 1,258. Overall, the ratio of ALC days to total inpatient days remained relatively constant from a low of 5.9% in 1989 to a high of 6.5% in 1988.

A small group of hospitals was able to furnish separate ALC information for infants The volume of ALC infants tripled in these facilities, from an average of 95 patients in 1987 to 281 in 1989 (Table 7-2). Infant ALC days also rose during this period but not as dramatically. Therefore, although hospitals were holding more infants beyond what was medically required, ALC lengths of stay declined over the three year period. The ratio of ALC days to total inpatient days for children less than one year of age fluctuated more widely than for the adult population. In 1987, infant ALC days represented 26% of total infant days. In 1988 it increased to 37% but dropped to 27% in 1989.

In addition to requesting three-year trend data, some survey questions required hospitals to furnish data for 1989 only. Responding NAPH facilities reported an average ALC monthly census of 115

Boarder Babies in Public Hospitals

"In a quiet room at Howard University Hospital, in Washington D.C., there is a healthy, 7-month-old baby who has spent her entire life there. The mother smoked crack cocaine during her pregnancy and abandoned the child a few days after she was born. The baby and dozens of other District children are residents of ad hoc orphanages...local hospitals that have become the only safety net for children who are sometimes abandoned before they are named. The children, who are medically ready to be discharged but have no place to go, are called boarder babies, and their number is growing. Beyond the human toll on the babies and on the limited nursing staffs, the financial costs are enormous: $100,000 a year or more for each child. The hospitals have picked up most of the costs. Medical staffs at the hospitals stress that their facilities are detrimental to healthy children. Boarder babies are in danger of contracting diseases from sick children. But even more troubling is the prospect of raising children in nurseries that are neither designed nor staffed to give the babies the kind of nurturing they should receive". Excerpted from an article by Marcia Slacum Greene, Washington Post September 11, 1989.

Since the article from which the above was taken appeared in 1987, Washington D.C has made some inroads in obtaining placements for many abandoned babies. However, boarder babies still remain in D.C hospitals and in safety net hospitals nationwide.

Adult Alternate Level of Care
NAPH Hospitals – 1987 to 1989

	1987	1988	1989	% CHANGE 1987–1989
ADULT ALC DAYS: *				
TOTAL	231,960	240,768	214,390	–7.6%
AVERAGE	12,208	12,672	11,284	
RANGE	29–34,447	73–32,263	22–25,802	
ADULT ALC PATIENTS: *				
TOTAL	7,784	8,715	8,471	8.8%
AVERAGE	410	459	446	
RANGE	3–984	8–979	3–1,258	

* Based on 19 hospitals

Table 7-1 Adult Alternate Level of Care

adults and 16 infants. In 1989, the average number of new ALC patients per month (26.6 adults, 18.1 infants) was slightly higher than average ALC discharges (26.2 adult, 17.6 infants). Adult patients experienced longer ALC average lengths of stay (28.8 days) than did infants (5.3). However, among infants, ALC days as a percentage of total hospital stay was greater than for adults (9.8% versus 2.8%).

The distribution of all ALC patients by payer source indicates that the majority of patients (45%) were covered by Medicaid, followed closely by Medicare (42%). Less than one-fifth of patients was covered by private insurance (4%), self pay (4%) and other sources of payment (5%) combined.

When asked to describe their ALC patient mix, half of all hospitals (n=12) with the ability to track ALC information noted that their mix was comprised of predominately elderly patients. Equal numbers of hospitals (n=7) reported AIDS patients and boarder babies as contributing to their alternate level of care patient mix. Psychiatry, neurology, and trauma patients constituted a portion of the ALC mix in a few facilities, as did patients with social problems of homelessness and drug abuse.

Survey results support the belief that ALC patients significantly impact at least some NAPH member institutions and that hospitals will be faced with mounting difficulties in finding alternative placements for these patients as their volume continues to rise. Some NAPH members have taken aggressive steps to expedite the timely discharge of patients. Strategies to manage ALC patients include the use of multidisciplinary teams to facilitate patient discharges and empowering hospital social workers and discharge planners to initiate placement arrangements prior to physician approval. Despite the best efforts of NAPH members to implement internal strategies to encourage effective ALC management, support from the external environment is needed as well. External approaches that would help relieve the ALC problem in public hospitals include the enactment of federal and state legislation to expand or increase Medicaid and Medicare coverage for sub-acute medical care and homemaker services; accelerated Medicaid approvals for hospital-based ALC patients; the creation of financial incentives for residential health care facilities to accept problematic patients (i.e., those with behavioral problems or heavy care needs); and the development of demonstration projects to encourage family members and significant others to provide required home care through the use of financial incentives.

Infant Alternate Level of Care
NAPH Hospitals – 1987 to 1989

	1987	1988	1989	% CHANGE 1987–1989
INFANT ALC DAYS: *				
TOTAL	4,513	7,473	5,924	31.3%
AVERAGE	903	1,495	1,185	
RANGE	0–2,535	0–5,420	0–3,955	
INFANT ALC PATIENTS: *				
TOTAL	475	830	1,406	196.0%
AVERAGE	95	166	281	
RANGE	0–276	0–381	0–983	

* Based on 5 hospitals

Table 7-2 Infant Alternate Level of Care

8

Patient Transfers and Dumping

Patient dumping, the colloquial term for economically-motivated patient transfers, has been a part of the public hospital experience for much of this century. The traditional role of the public hospital in serving as a hospital of last resort, lead patient transfers to public hospitals to become commonplace. Until recently, economic transfers were seldom questioned. In fact, in the Kellogg Commission report on public general hospitals released in the late 1970s, the issue was not discussed at all.

In recent years, however, patient transfers have begun to receive a great deal of attention, on the part of the health care community, the media, and the general public. The increased attention to this issue is primarily a result of the growing number of reports of tragic consequences due to inappropriate transfers. Of course, under some circumstances, transferring an indigent patient to a public hospital for care is completely appropriate. One of the key roles of the public hospital is to care for those with no insurance. However, many public hospitals have reported an increase in the number of transfers that endangered the life or health of the patient, either because the patient was not medically stable for transport, or because the receiving hospital was not given information on the patient or an opportunity to refuse the transfer when staffing or patient loads make caring for additional patients too difficult. Too often, transfers take place without sufficient attention to the safety and interests of the patient. In addition, for many cities the volume of indigent patients exceeds the limits of local tax subsidies to the public hospital, and not-for-profit hospital's tax exempt status is viewed by many to require some amount of care to the poor.

Horror stories about patient transfers, including transfers that ultimately resulted in the needless death of the patient, have focused the attention of the public and legislators on this issue. In August of 1986, Congress amended the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) to establish criteria for safe transfers of critically ill or injured patients and women in active labor. The amendment requires that hospitals evaluate and, if necessary, stabilize the patient prior to transfer. If stabilization is not possible, the physician must certify in writing that the benefits to the patient outweigh the risks of transfer, the receiving hospital must agree to accept the patient, the hospital must send records with the patient, and the patient must be transported with life support equipment if necessary. The Health Care Financing Administration (HCFA) is responsible for enforcing the law.

In the first year and a half after the amendment was passed, just 129 complaints had been filed with HCFA, and in only two cases were any penalties levied. This, and other complaints regarding the adequacy of COBRA in correcting the problem of inappropriate patient dumping led to hearings in March of 1988 by the House Committee on Government Operations. At these hearings, several witnesses testified to the inaction of HCFA in enforcing the law, and to the difficulty hospitals have in making complaints against hospitals in their communities with whom they need to cooperate. The Committee ultimately recommended, in its report on the issue,[20] that HCFA publish regulations implementing the COBRA amendment, undertake to educate the public of its rights, inform hospitals and doctors of the law and require hospitals to post notices in emergency departments and to notify patients prior to transfer. The committee also recommended that the regulations should prohibit all transfers except those required for adequate medical care, and should require the informed consent of the patient prior to transfer, and recommended that HCFA be required to establish a system for periodic review of transfer files in every hospital.

In the Omnibus Budget Reconciliation Act (OBRA) of 1989, amendments to the patient dumping restrictions were enacted. Effective July 1, 1990, these modifications accomplish some of the Committee on Government Operations' recommendations. They include provisions making hospitals liable for the acts and omissions of its agents and physicians. They set as a condition of participation in the Medicare program hospitals' development of policies to ensure compliance with the law and the maintenance of records on all transfers. Hospitals are required to post

- **A study of patient transfers at Cook County Hospital in Chicago revealed that of 500 patient transfers, one fourth of the patients required admission to an intensive care unit. Nearly one fourth of the patients were found to be unstable when transferred. Transferred patients had a mortality rate almost three times that of non-transferred patients at Cook County Hospital.**
- **At the Regional Medical Center at Memphis, during a three month period, 146 transfers were received without prior telephone authorization. Almost all (91%) were sent for economic reasons. One out of four was found to be unstable upon arrival.**
- **Parkland Memorial Hospital in Dallas put in place in the mid 1980s a formal, and stringent, policy for patient transfers, in an attempt to reduce inappropriate transfers.**

signs informing the public of its rights under the law, and the hospital must obtain a written consent or refusal to transfer[11].

To date, HCFA has released regulations only on the requirement for hospitals to post signs notifying patients of their rights under the law. In addition, the House Ways and Means Subcommittee on Health approved a proposal to modify further the federal patient transfer law. The committee's proposal would provide for a negligence standard with civil monetary penalties, and clarify the standard for exclusion from Medicare for violations.

The Challenge to Tax Exempt Status of Non-Profit Hospitals

In recent years, partly in response to the issue of patient dumping, increased attention has been paid to the obligations of private not-for-profit hospitals in caring for the uninsured. To many, a hospital's tax exempt status implies an obligation to provide "community services." While the definition of services is unclear, some hospitals are coming under fire for not providing care to the uninsured in order to justify continued tax exempt status.

A report issued by the General Accounting Office states that there is currently an uneven distribution of charity care across hospitals, with government-owned hospitals and large urban teaching hospitals providing a disproportionate amount of charity care. While a majority of nonprofit hospitals offered community services in addition to providing some charity care, the community services were generally not targeted to the poor. The report also concludes that "if Congress wishes to encourage nonprofit hospitals to provide charity care and other community services, it should consider revising the criteria for tax exemption.[12]"

[10]Equal Access to Health Care: Patient Dumping Thirty seventh report by the Committee on Governme Operations, March 25, 1988.

[11]Brown, "Patient Dumping" After OBRA '89: New Problems for Hospitals and Physicians Alike, The Health Law.

[12] Nonprofit Hospitals: Better Standards Needed for Tax Exemption," GAO Report to the Chairman, House Select Committee on Aging. May, 1990.

9

Staffing and Medical Education

Safety net hospitals, in addition to providing many valuable services to their communities, also serve as major employers within their communities. The labor-intensive nature of hospitals, combined with the size of public hospitals means that staffing issues play an even more critical role in these hospitals than in other hospitals. Fifty-eight NAPH member hospitals employ a total of 156,000 people. The average NAPH member hospital employed a total of 2,684 full-time equivalents, or 5.1 per staffed bed in 1988 (See Table 9-1). These employees included an average of 549 Registered Nurses, and 109 Licensed Practical Nurses per hospital. Consistent with their large size and complexity, NAPH hospitals employ a much larger staff than other U.S. acute care hospitals, which employ an average of 575 people per hospital. NAPH member hospitals also provide training to a large number of residents, averaging 191 medical and dental residents per hospital in 1988. Payroll in NAPH hospitals averages $69.7 million per hospital, as compared to $13.5 million in other general hospitals. (See Table 9-2).

Staff Recruitment and Retention

Because they are extremely labor-intensive, and provide such a large amount of care, public hospitals are particularly sensitive to staffing issues. Public hospitals often have low salary structures, often a result of insufficient operating funds as well as restrictive civil service hiring practices associated with being a branch of local or state government. These factors, coupled with the workload expected of public hospital employees, often place these hospitals in a less-than-advantageous position to compete in the local health care staff market. When the supply of health care workers falls below demand, public hospitals often feel the effects more strongly and more quickly than other providers.

In March of 1988, NAPH surveyed its membership on the recruitment and retention of nurses. For 1986 and 1988, these hospitals were asked to provide data on nursing staff composition, vacant positions and turnover rates, reliance on nurse contracting, in-house pools and offshore recruitment, and nursing salaries. Hospitals were also asked about the nature and extent of the nursing shortage in their area, and how this affects their recruitment and retention.

Nurse Staffing in Public Hospitals

Forty-seven NAPH hospitals reported an average of 408 RNs on staff as of April 1, 1988, with over 90% in non-administrative positions (See Table 9-3). Hospitals reported a 4.6% decrease for RNs in non-administrative positions between 1986 and 1988, accompanied by an increase of about 8% in administrative RNs. The number of LPNs/LVNs and nursing assistants also declined dramatically, by more than 8% over the two years. During this time, there was a striking increase in the number of "other" nursing personnel, which rose more than 30%. Total nursing staff declined from an average of 758 per hospital in 1986 to 741 in 1988. Over the course of these two years, the average nursing salary increased just 7%, from $26,834 to $28,725.

Almost without exception, hospitals reported that they are experiencing difficulty in recruiting RNs. NAPH hospitals reported only a 2% increase in the number of RN positions budgeted between the two years (See Table 9-4). The number of vacant RN positions, however, increased much more substantially, 80% in two years. Fifty-two RN vacancies existed in the average NAPH hospital in 1986. By 1988, vacant posiions averaged 94 per hospital. Vacancies as a percentage of budgeted positions increased from 9% to 16%.

Further evidence that the nursing situation in public hospitals has worsened is demonstrated by the over rate and the number of days positions remain

Donna Polston, RN, performs lab work as one of her many duties at Vanderbilt University Hospital.

Staffing in Public Hospitals – 1988

	Average FTEs	Percent of staff	FTEs Per Bed
Administration	31	1.1%	0.1
MDs	69	2.6%	0.1
Residents	187	7.0%	0.4
Dentists	2	0.1%	0.0
Dental Residents	4	0.1%	0.0
RNs	549	20.4%	1.0
LPN's	109	4.1%	0.2
Ancillary Nursing	205	7.6%	0.4
Physicians Assistants	4	0.2%	0.0
Nurse Pract.	13	0.5%	0.0
Medical Records	24	0.9%	0.0
Pharmacists	27	1.0%	0.1
Pharm Tech.	22	0.8%	0.0
Medical Tech.	70	2.6%	0.1
Other Lab	54	2.0%	0.1
Dietician	10	0.4%	0.0
Diet Tech.	24	0.9%	0.0
Radiology	59	2.2%	0.1
Therapists	23	0.9%	0.0
Speech/hearing	3	0.1%	0.0
Resp. Ther.	21	0.8%	0.0
Resp. Tech.	11	0.4%	0.0
Psychologists	4	0.2%	0.0
Social Workers	30	1.1%	0.1
Other	1,130	42.1%	2.1
Total FTEs	2,684	100.0%	5.1
Average Number of Staffed Beds	526		

Table 9-1 Staffing in Public Hospitals

vacant (See Table 9-5). Hospitals reported a 16% increase in turnover rates for RN positions, and a 21% increase in the number of days an RN position remained vacant, from 80 to 97 days.

More than 60% of public hospitals reported that difficulties in recruiting nurses were compounded by salary inequities with the private sector (See Table 9-6). Hospital location also complicated hospital recruitment efforts for a majority (57%) of hospitals. Benefits packages that are not comparable with the private sector were a problem for 51%, and the types of patients treated and services offered were a hindrance in 51% of NAPH hospitals.

Eighty-eight (88%) percent of public hospitals have developed in-house pools to assist in maintaining sufficient nursing coverage. Eighty-three (83%) utilized contract nurses in 1988, up from 75% in 1986. This is well above the 40% rate reported by AHA for hospitals nationwide. Slightly more than half of NAPH hospitals used offshore recruiting to offset nursing vacancies. Many hospitals reported using other personnel such as LPNs, clerks and aides to carry out some nursing duties, freeing up RNs to concentrate on patient care tasks. Several hospitals implemented training programs to upgrade less experienced nurses. Some public hospitals have established shift and weekend salary differentials, others provide

tuition assistance and continuing education incentives. Also, hospitals attempted to increase benefit packages, by including day care, preferred parking, and uniform allowances. Other NAPH hospitals have used recruitment and relocation bonuses, and bonuses for RNs who pass the state board and agree to remain at the hospital for 2 years.

Recently, the American Hospital Association reported that the nursing crisis continues, based on the "growing demand for bedside nurses, the shrinking number of people entering the work force, and competing career opportunities." While public hospitals feel the effects of these problems as well, their situation is exacerbated by the patient populations these hospitals serve, stress, increasing demand for services, and an inability to keep pace with private sector salaries and benefits. Public hospitals, like others, believe that the solution lies in additional nursing education support at the state and federal levels, creating effective incentives and enhancing the image of nursing as a profession.

Staffing in NAPH and Other Short–Term General Hospitals – 1988

	NAPH	Other
	(Average per Hospital)	
Total FTE's	2,684	575
RNs	549	138
LPNs	109	31
Payroll (thousands)	69,737	13,504
Benefits (thousands)	6,509	2,526
Benefits as a percent of payroll	9%	19%

Table 9-2 Staffing in NAPH and Other Short Term General Hospitals

"The current vacancy rate (for nursing staff) is at 16% with a turnover rate exceeding 20%. This factor alone has a two-fold impact on the district. First, increased expenditures for contract labor and overtime which leads to staff discontentment and burn-out. Second, and more critical, in an era of staffing shortages, the operational ability to meet the patients demands...is severely hampered."

—Lois J. Moore, President and CEO Harris County Hospital District. Statement presented to the 1990 IRB Challenges Conference, Houston, Texas.

"Our vacancy rate for nursing positions stands at 17% and we scramble daily to ask nurses to work overtime and to bring in expensive agency help in order to keep desperately needed beds open."

—Statement of James Mongan, MD Executive Director of Truman Medical Center, Kansas City, Missouri before the House Ways and Means Subcommittee on Health, April 4, 1990.

Medical Education

The mission of public hospitals, of caring for all who seek care, also includes a teaching component, providing a setting for the education of medical and dental professionals. In 1988, 40 NAPH member hospitals provided residency training for almost 7,500 residents, about 12% of all the residents placed in hospital settings that year (See Table 9-7). While other acute care hospitals averaged .06 residents per bed, NAPH hospitals averaged .36 per bed. The dual missions of providing medical care and teaching programs are closely interdependent. The hospital relies heavily on the residents to provide services demanded by patients, and the residency programs rely on the public hospital's scope to draw patients with unique and challenging problems to be sure that the residents training is complete.

In recent years, some public hospitals have been facing increasing difficulties in attracting outstanding residents. Their inner-city location, the increase in the r[illegible] AIDS patients treated, and the growth in the drug problem in the inner city has made some public hospitals less successful in attracting residents in some fields. In addition, there has been a shift toward ambulatory training of residents which has accompanied the national trend toward emphasizing outpatient and preventive care. For the most part, however, the wide scope of services offered in public hospitals still provide an excellent educational opportunity for doctors-in-training, and it is clear that these residents provide an important service in the care of patients of safety net hospitals. In fact, most of the medical care provided in public hospitals is provided by residents, under the supervision of an attending physician, in both the inpatient and ambulatory services. The attending physicians, as well as the residents, are generally provided through an affiliation agreement between the hospital and a medical school. The importance of the medical school affiliation, and the necessity to balance the goals of patient care and teaching in the public hospital, is apparent.

In the past several years, attention has been called to the long-standing method of educating doctors—the long hours at the hospital. In a most dramatic case, New York State approved modifications to the state's Hospital Code, mandating a reduction in

Nursing Personnel in Public Hospitals 1986 and 1988

Nurse Category	April 1, 1986				April 1, 1988				Percent Change	Percent Change Per Bed
	Number	Average	Percent	Avg. per Bed	Number	Average	Percent	Avg. per Bed		
RNs (Non–Administrative)	17,987	391	52%	0.69	18,288	373	50%	0.66	−4.6%	−4.2%
RNs (Administrative)	1,523	32	4%	0.06	1,711	35	5%	0.06	7.8%	8.1%
LVNs/LPNs	4,794	104	14%	0.18	4,672	95	13%	0.17	−8.5%	8.2%
Nursing Asst./Attend.	7,600	165	22%	0.29	7,263	151	20%	0.27	−8.4%	8.1%
Other	2,821	66	9%	0.12	3,825	87	12%	0.15	32.5%	33.0%
Total	34,725	758	100%	1.34	35,759	741	100%	1.31	−2.2%	−1.9%
Hospitals	47									

Table 9-3 Nursing Personnel in Public Hospitals

Budgeted and Vacant Positions in Public Hospitals – 1986 and 1988

	1986 Total	1986 Avg. per Hospital	1988 Total	1988 Avg. per Hospital	Percent Change
Budgeted RN Positions	26337	573	28578	583	2%
No. of Hospitals	46		49		
Vacant RN Positions	2400	52	4503	94	80%
No. of Hospitals	46		48		
Vacant RN Positions as Percent of Budgeted Positions		9%		16%	7%

Table 9-4 Budgeted and Vacant Positions in Public Hospitals

residents' worki[illegible]hours and an increase in the amount of supervision provided by attending physicians.

New York's regulations have had a significant impact on public hospitals in the state. Queens Hospital Center, in response to the new regulations, evaluated the non-physician tasks provided by residents. In order to comply with the code, Queens Hospital estimates that it will spend $1.7 million on new ancillary staff positions (about 150 FTEs) and on an IV Therapy Team. The hospital is not sure whether or not these additions will compensate for the necessary reduction in resident working time. There is speculation that the regulations passed in New York State will serve as a model for other states, as well as for federal accreditation agencies, in bringing medical education reform to other parts of the country.

Hospital Turnover Rate in Public Hospitals 1986 and 1988

	1986	1988 % Change	
Turnover (as a % of total staff change)	19%	22%	16%
Days Position Remained Open	80	97	21%
Number of Hospitals	44	45	

Table 9-5 Hospital Turnover Rate in Public Hospitals

Nurse Recruitment in Pubic Hospitals

Basis for Difficulty in Recruitment in 1988:	Percent of Hospitals
Salaries not comparable to private sector	61%
Hospital location	57%
Benefits not comparable to private sector	51%
Types of patients/services	51%
Other	61%
Number of hospitals	49

Table 9-6 Nurse Recruitment in Public Hospitals

Residents in NAPH and Other Acute Care Hospitals – 1988

	Total Acute Care	NAPH	NAPH as a % of Total
Residents:			
Total	64,060	7,480	11.7%
Average per hospital	11	191	
Average per bed	0.06	0.36	
Number of Hospitals	5,579	40	0.7%
Average Number of Beds	170	526	

Table 9-7 Residents in NAPH and Acute Care Hospitals

The Bell Commission

In June of 1988, the New York State Hospital Review and Planning Council approved major changes in the state's Hospital Code, mandating a reduction in residents' working hours and an increase in the amount of supervision provided by attending physicians. These regulations were recommended by the New York State Ad Hoc Advisory Committee (known as the Bell Commission after Bertrand Bell, the Committee Chair). The Bell Commission recommended these changes in an attempt to improve the quality of patient care in teaching hospitals. The committee was formed in response to the death of Libby Zion, daughter of a New York lawyer and writer for the New York Times, after admission to New York Hospital's emergency department for fever, chills and muscle aches. A grand jury investigation of Ms. Zion's death did not attach blame to New York Hospital, a private teaching hospital, or to the residents who provided her care, but instead blamed the system of medical education, citing an inadequate level of expertise in the emergency department. The grand jury stated that her death could have been prevented had Ms. Zion been cared for by more experienced staff.

The New York State regulations require that—

- emergency departments have 24-hour attending physician coverage;
- residents and attending physicians work no more than 12 consecutive hours in emergency departments with more than 15,000 annual visits;
- residents in several services cannot work over 80 hours per week, no more than 24 consecutive hours, must have at least 8 hours of non-working time between shifts, and at least 24 consecutive hours off each week; and
- teaching hospitals must provide sufficient ancillary services, such as IV services, transport, and phlebotomy services to meet patient need.

10

Governance, Administration, and Capital

The primary strengths of the public safety net hospital—its public mission and close ties with local government—can also present unique challenges and constraints. These include legal restrictions such as inappropriate procurement and civil service requirements, budget inflexibility and bureaucratic barriers to efficient decision-making. Public sector constraints can also severely limit access to capital and curtail on capital financing options. The purpose of this chapter is to outline briefly some of the administrative, governance, and capital financing constraints faced by public safety net hospitals, and to describe some possible solutions.

The Impending Capital Crisis for Safety Net Hospitals

Apart from obtaining adequate reimbursement for their millions of uninsured and underinsured patients, the most pressing problem facing urban safety net hospitals in the 1990s will be gaining access to (and being able to repay) needed capital for a variety of purposes. The nation's urban safety net hospitals are collectively facing a capital crisis today. The average age of physical plant among the 57 NAPH member hospitals surveyed is nearly 26 years, in comparison to the national average of only seven years. And the years do not treat public facilities kindly—the high occupancy rates experienced in these facilities (described in detail in Chapter 2) result in far more rapid deterioration of plant and equipment than in the typical hospital.

This capital crisis is the consequence of years of severe underfunding in the public hospital sector: rather than reduce operating expenses by turning indigent patients away, many hospitals have instead canceled or deferred needed investment in plant and equipment. Operating costs then rise, with the increased maintenance costs and decreased efficiencies of the now-deteriorated buildings and equipment, leaving even less funding available for capital replacement. In addition to increased operating expenses, deteriorated conditions result in a diminished capacity to provide quality care to all patients in need, stemming from inadequate and outmoded equipment, unacceptable or unsafe physical conditions, an inability to attract and retain adequate staff at all levels, an inability to raise revenues through insured patients, and the creation of constant administrative crises. Such conditions frequently lead to life and safety code violations, and can even result in a hospital's loss of HCFA certification or JCAHO accreditation.

Studies of capital investment in the New York City Health & Hospitals Corporation over the last three to five years starkly illustrate this pattern of underfunding. The NYCHHC hospitals' capital investment was far below the industry average, by a wide variety of measures:

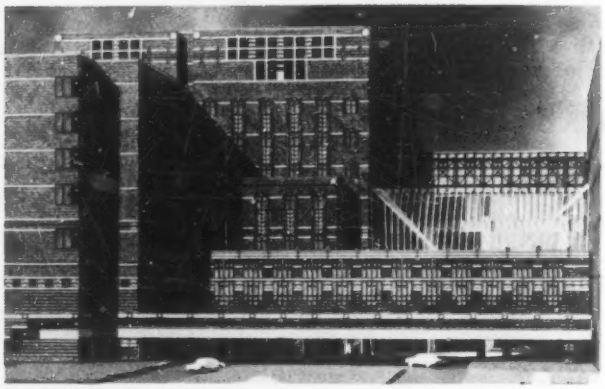
- reconstruction investment per bed was 32% below the industry average;
- the ratio of capital spending to operating expenditures was 59% below average;
- per bed construction was 34% below average; and
- total capital expenditures per bed, exclusive of major construction projects and acquisitions, fell 41% below the industry standard.

More recent studies which compare NYCHHC's hospitals with nearby, directly comparable private facilities (rather than a national average) reveal a similar, but even more dramatic, pattern of differences in capital expenditures.

A comparison of expenditures by Louisiana's statewide Charity Hospital System with a group of 48 private hospitals in Louisiana is even more startling. Recent studies revealed that in fiscal year 1988, the Charity System spent an average of $1,741 per bed for building improvement and fixtures, as compared to an average of $11,407 per bed in the private hospitals. For fixed and movable equipment, Charity expenditures were $1,178 per bed, in contrast to $12,539 per bed in the private sector group. The Charity System's undepreciated historical cost of all plant, property and equipment was $111,153 per bed, or 58% of the historical cost of $190,681 per private sector bed. Thus, the Charity System's 1988 capital expenditures were only 15% and 9%, respectively, of comparable private sector expenditures! The difference in historical expenditures, while less dramatic, indicates that the 1988 experience is not a new problem, but rather a part of a consistent pattern of underfunding in the Charity System.

The experiences of NYCHHC and the Charity System are far from unique. While few other public hospitals have obtained such clear documentation, it is obvious that these factors have lead to similar consequences throughout the country. As a result, the magnitude of current capital needs among NAPH members is enormous.

For example, Los Angeles County has recently approved a $2.3 billion, ten-year capital replacement plan for its seven-hospital system. This amount includes the construction of three new replacement facilities, and a number of smaller projects. The LAC-USC Medical Center, alone, will incur a staggering



Boston City Hospital
Photo by Edward Jacoby Courtesy of Hoskins Scott Taylor & Partners, Inc./Cannon

$111 million in annual debt service over 38 years in financing its replacement facility. Similarly, NYCHHC's ten year plan for 1989-1998 included $2.6 billion in essential capital expenditures. A 1990 capital planning review of eight hospitals in Louisiana's Charity System identified $365 million in basic capital needs over the next five years. Capital needs at just a few other NAPH member hospitals—Grady Memorial, Cook County, Contra Costa County, Boston City—indicate that America's safety net "infrastructure" could easily absorb $10 billion in new capital over the next several years.

Where will this new capital come from? Some safety net hospitals— Parkland Memorial, Miami's Jackson Memorial, Houston's Harris County Hospital District—have already obtained needed capital through direct G.O. financing (the Texas hospitals), or a combination of G.O. and revenue bond financing. Grady Memorial has also recently obtained approval for G.O. financing. The chief concern of these public safety net hospitals will be **how to pay the debt service** on capital already obtained, given the significantly disproportionate services provided to uninsured and underinsured patients.

For others, access to G.O. financing is not even an available option. For them, assistance in obtaining needed capital will be key. In that regard, Boston City Hospital provides a recent bright spot in this otherwise dismal review of capital access. On October 30, 1990, this hospital became the first major urban public hospital to obtain federal mortgage insurance through Section 242, a Federal Housing Administration program under which the federal government insures hospital construction loans by private lenders. This guarantee will enable BCH to issue $170 million in tax-exempt revenue bonds for the construction of a new 356-bed facility and the renovation of several other buildings. While the mortgage insurance will enable BCH to obtain very favorable interest rates on the bonds, this program is not without its own costs. Notwithstanding the fact that NAPH originally obtained passage of an amendment in 1984 to open the Section 242 program to public hospitals, it has taken the hospital nearly four years to negotiate this transaction with the FHA. BCH's public status is the acknowledged reason for the delay in approval; because the hospital did not fit the FHA's private application and reporting categories and procedures, which were established for private hospitals, each aspect of the relationship had to be worked out in advance. However, approval was ultimately received, and the hospital plans to begin construction in the near future.

As this illustrates, however, public hospitals face special barriers in obtaining capital financing:

- the high proportion of uncompensated and indigent care often leads to low or negative operating margins;
- their ownership and governance structures may preclude them from directly issuing revenue bonds or utilizing other financing vehicles available to their private counterparts;
- where revenue bonds are legally feasible, the bond rating may be low because the bond market often views the local appropriations on which many public hospitals rely as too uncertain to be included in annual revenue calculations;
- the low operating margins may also render private bond insurance and similar credit enhancement unavailable to, or unaffordable for, these hospitals; and
- the growing budget constraints of many local governments have resulted in their unwillingness or inability to issue general obligation bonds, raise taxes, or otherwise fund major capital projects for the public hospitals.

Because of these and other factors, access to affordable capital is rapidly becoming the top priority for NAPH members. And as the NAPH policy agenda described in Chapter 12 clearly illustrates, a major safety net capital financing initiative will be a major part of the NAPH legislative agenda this year.

Public Hospital Administration and Governance

Many of the administrative problems faced by public safety net hospitals can be traced to their legal status as agencies of government. As a result, one of the survival strategies undertaken by certain public hospitals in recent years has been a partial or total reorganization of the hospital's governance and legal structure. Reorganization of a hospital directly operated by its state or local government may take various forms, and it is important to note that many

of these forms do not involve so-called "privatization." Among the most common are the creation of an independent hospital board within the existing governmental entity; the transfer of the hospital to a new hospital district or authority; or its sale or lease to a newly created, non-profit corporation.

The examples listed above fall along a continuum of independence, ranging from direct governmental ownership and operation (e.g., where the city council acts as the governing board) to operation by a quasi-private, non-profit corporation. However, it is important to note that even the latter structure falls far short of the sale or lease of a hospital to an existing third party. In effect, in this type of reorganization, the hospital is transferred by its governmental owner to a *newly created* non-profit corporation, with a separate board of directors that is typically appointed, at least initially, by the governmental body.

There are strong arguments to be made both for and against legal reorganization. In fact, the only clear statement that can be made is that the appropriateness of any of these structural changes for any particular public hospital will depend entirely on that hospital's unique local circumstances.

Public Hospital Administrative Constraints

Powerful arguments for reorganization can be made in cases where a public hospital is saddled with a host of legal and administrative obstacles which leave the hospital strait-jacketed in its fight for survival. The operation of an acute care hospital is far more complex than most of the governmental functions for which legal and administrative controls were created. Institutionally, a hospital is a set of intricate and interrelated programs and functions operating in close proximity. Its operation depends on advanced and rapidly changing technology, and both plant and equipment have a far shorter useful life than is typical in other agencies of government. Further, no administrative and fiscal environment has changed more rapidly in recent years than that of the hospital sector. The rules and procedures that are sometimes cumbersome but tolerable for the operation of a local sanitation department present problems of a higher order for acute care hospitals. These obstacles may include:

- civil service or procurement constraints that may be appropriate for typical governmental activities, but are clearly unsuited to the hospital industry;
- added layers of strategic or operational decision-making which often preclude a rapid response to critical issues;
- budgetary inflexibility, impeding the shift of funds to respond to changing needs;
- limited access to capital or the unavailability of options such as revenue bonds, which might be improved by adopting non-profit status, or otherwise increasing the hospital's independence;
- absence of confidentiality which may be critical for effective strategic planning in a competitive local health market;
- the inability to attract effective top management or medical staff, in competition with the private sector, due to the political or economic realities of working for a government entity;
- legal constraints which prevent the hospital from entering into affiliations or joint venture arrangements that may otherwise appear necessary or beneficial; or
- the compromise of effective governance when elected officials who act as *board members* are subject to too many competing demands for their time or political support.

On the other hand, there are frequently valid concerns about the effects of a possible reorganization, particularly reorganization as a non-profit corporation. These concerns include the need for assurances that the indigent care mission and public health programs of the hospital will be maintained; accountability for public funds if continued subsidies are required; and protection of the public interest in facilities that were often constructed with state or local appropriations or general obligation bonds.

Where successful reorganization has occurred, it has usually been because more than one of the elements that favor it were present, while the legitimate governmental concerns were successfully addressed through careful design of the new governmental entity or crafting of the new corporation's charter, transfer or lease agreement, or funding process. Some of the more successful reorganizations have been partial, with significant residual control over the hospital's mission and expenditure of governmental funds remaining with the governmental entity.

Examples of metropolitan area safety net hospitals that have successfully reorganized as non-profit corporations include the Regional Medical Center at Memphis, the Truman Medical Center (Kansas City), the St. Louis Regional Health Care Corporation, Memorial Medical Center of Savannah, and several state university hospitals, including those of Maryland, Florida and West Virginia. Independent governing boards have been created within the local governments to operate Jackson Memorial Hospital (Miami), D.C. General Hospital (Washington, D.C.), and the New York City Health & Hospitals Corporation. And Parkland Memorial Hospital (Dallas), Grady Memorial

Hospital (Atlanta), Tampa General Hospital, and North Broward Hospital District (Fort Lauderdale) are a few of the successful hospitals governed by local hospital authorities or districts (See Table 10-1).

Examples of Corporate Structures in Selected NAPH Member Hospitals

1. Direct Operation by Government

No separate board other than city council, county supervisors, etc.

Alameda County Department of Health
Los Angeles County Hospitals
Santa Clara Valley Medical Center
Denver Department of Health & Hospitals
SUNY Health Sciences Centers
Cook County Hospital
San Bernardino County Medical Center
Charity Hospital System of Louisiana
Hawaii State Hospital System
LSU Medical Center, Shreveport
Contra Costa County Health Services Agency

2. Separate, Dedicated Public Governing Board

Including public benefit corporations, health commissions, and advisory boards appointed by local or state government.

Brackenridge Hospital, Austin
Harborview Medical Center, Seattle
Erie County Medical Center, Buffalo
New York City Health & Hospitals Corporation
Jackson Memorial Hospital
D.C. General Hospital
San Francisco General Hospital
Nassau County Medical Center
Boston Department of Health & Hospitals
Pontiac General Hospital
Hurley Medical Center, Flint
Westchester County Medical Center

3. Hospital District or Authority

Public hospitals operated as separate, independent governmental entities.

Parkland Memorial Hospital
Harris County Hospital District, Houston
Grady Memorial Hospital
Tampa General Hospital
Bexar County Hospital District
Northwest Texas Hospital, Amarillo
Phoebe Putney Memorial Hospital, Albany, Ga.
Medical Center of Central Georgia, Macon
Erlanger Medical Center, Chattanooga
Tarrant County Hospital District, Fort Worth
Memorial Hospital, Hollywood, Fla.

4. 501(c)(3) Non-Profit Corporation

NAPH members who have either converted to non-profit status or are non-profit hospitals with a safety net mission.

Truman Medical Center, Kansas City
St. Louis Regional Medical Center
Regional Medical Center at Memphis
Memorial Medical Center, Savannah
St. Lukes/Roosevelt Medical Center
University of Chicago Medical Center
St. Mary's Hospital, East St. Louis

Source: Powell, Goldstein, Frazer & Murphy, 1990

Table 10-1 Examples of Corporate Structures in Selected NAPH Member Hospitals

11

Innovation and Excellence

Public hospitals, faced with many challenges, have responded over the years with ingenuity and compassion. Today, public hospitals continue to serve as a health care safety net for the nation's poor and medically disenfranchised, and at the same time to furnish critical specialized services to the community at large through centers of excellence in many medical disciplines. Through these roles, public hospitals are truly the health care safety net for all Americans.

Innovation in Safety Net Hospitals: The 1990 NAPH Safety Net Awards

In spite of, or perhaps in part because of, the many challenges encountered by public hospitals in carrying out their duties, public hospitals have developed creative, compassionate programs, designed to meet the diverse and changing needs of their patient populations. The programs described below are just a sample of the many unique and successful things safety net hospitals have done to meet the needs of their communities. The programs described below were nominated for NAPH's first annual Safety Net Awards. NAPH instituted the Safety Net Awards Program in 1990 to recognize those hospitals that have adopted creative approaches to assist them in performing their role as safety net providers. The awards program called for nominations in three areas, Patient Care, Community Service, and Development.

Patient Care Management

- **Goldwater Memorial Hospital's AIDS Volunteer Program** (Safety Net Award Winner, 1990)

The AIDS Volunteer Program was started at Goldwater Hospital to provide emotional and social support and recreational activities to AIDS patients admitted to a long term health facility. Individuals interested in volunteering undergo two interviews before they are accepted for training. Training consists of both a 3-hour classroom session and a hands-on session. Volunteers must also pass a complete medical examination.

Volunteers work in teams of two or three, and commit to at least one three-hour shift per week. Volunteers are responsible for activities such as: advocacy, "theme" parties, table games, arts and crafts, music and entertainment, out-trips, hair cutting, discussion groups, funeral arrangements, feeding, movies and much more. Confidential progress notes are kept by volunteers and submitted to the volunteer department staff to facilitate ongoing communication. The volunteers free the staff to concentrate on concrete medical care by taking care of the vital, non-medical needs of the patients.

- **High Desert Hospital's Cooperative Obstetric Program** (Safety Net Award Honorable Mention, 1990)

High Desert Hospital and Antelope Valley Hospital Medical Center (AVHMC) initiated a cooperative program to provide obstetrical services to low income and indigent mothers. The program was developed in response to a crisis situation faced in 1987 in which poor women who had received no prenatal care and arrived to deliver at the Emergency Room at AVHMC.

Through the partnership, High Desert Hospital provides outpatient prenatal and postpartum care. High Desert Hospital medical staff physicians perform deliveries at AVHMC, and AVHMC provides inpatient services. The program has expanded considerably from the 87 patients seen in July, 1987 to the 350-400 patients per month it now receives.

- **Queens Hospital Center's Program to Improve Physician Accountability and Quality Assurance of Medical Record Documentation**

Queens Hospital Center has developed a program that has improved the mechanisms of attending physician accountability and documentation of patient care. The first step in the program was to establish appropriate departmental relationships to ensure the identification and assignment of attending physicians and medical records specialists to each case upon admission. The Medical Staff also established guidelines of documenting an admit note within 48 hours and a progress note at least weekly. Documentation was expanded beyond the presence or absence of admission notes and progress notes in 1987.

The results of the program are: better physician accountability, improved clinical pertinence, resolution of regulatory citations, improved reimbursement (casemix), accelerated cash flow, timely record completion, and a better working relationship with the medical staff. It has been implemented smoothly and without additional expense resources.

- **St. Louis Regional Medical Center's Mother/Baby Postpartum Care Program**

The concept of mother/baby postpartum care has been embraced at the St. Louis Regional Medical Center. In this program, newborn infants are taken to their mothers' rooms on the post partum floor and remain with the mothers throughout the day. Nursing

staff works with the mother and baby to teach new mothers important child care concepts. Because the nursing staff is able to observe the bonding between mother and child, potential problems in this area are more easily observed. The program has been well accepted by patients and serves as a model for other hospitals.

- **Erie County Medical Center's Western New York Alternate Level of Care Task Force**

A community-wide effort to address the seriousness of the growing number of Alternate Level of Care (ALC) patients in Buffalo and Erie County was initiated by Erie County Medical Center in the form of a Task Force. The Erie County ALC Task Force was formed with the purpose of developing action plans for managing the increasing number of problems created by ALC patients. The Task Force included members of key agencies at the community, county, and state level to allow full coverage of the issues preventing the placement of ALC patients. The task force has submitted a proposal to initiate the concept of Supportive-Housing in New York State to the State Department of Social Services for approval.

- **Tampa General Hospital's Transfer Center**

Tampa General Hospital has developed a center especially designed to deal efficiently with requests for the transfer of patients from other hospitals. All requests for the acceptance of inter-hospital transfers are initiated through the Tampa General Transfer Center, a component of the hospital's admitting department. The Center assures that the scarce resources of Tampa General's tertiary care facility are used to optimal advantage.

Transfer agreements with the referring facility are a major factor in the inter-hospital relationship. The referring facility is asked to commit to accept the patients back after tertiary care is completed. The Center also informs the referring facility of details concerning the patient's arrival and treatment. Since 1988, the Center has saved Tampa General approximately $3 million. Most of the savings have come from preventing nearby hospitals from "dumping" uninsured patients.

Community service

- **Parkland Memorial Hospital's Community Oriented Primary Care** (Safety Net Award Winner, 1990)

The Community Oriented Primary Care (COPC) program of Parkland Memorial Hospital blends traditional medicine with public health education to improve the overall health status of the target

A family practice physician has a close look at a young patient at the East Dallas Health Center—participant in Parkland Memorial Hospital's Community Oriented Primary Care (COPC) project.

community, and reduce the need for expensive secondary and tertiary care. The overriding philosophy is to prevent illness, making medical intervention unnecessary. The COPC model calls for the presence of a health center within the community to be served. Its delivery hours extend beyond the traditional 9-5, to include evenings, weekends, and on-call. Since its implementation in July of 1989, COPC's accomplishments include the development of two community health centers, the introduction of programs to assess cancer risks, and perform cancer screening, and the generation of extensive public-private initiatives to support health status improvement.

- **Regional Medical Center of Memphis' Sunrise Program** (Safety Net Award Honorable Mention, 1990)

Teenage pregnancy has become today's major perinatal challenge. The Sunrise Program at The Regional Medical Center at Memphis, in an effort to meet this challenge, assists pregnant teenagers through pregnancy, delivery, the postpartum period, parenting, and the first two years of her child's life. A multidisciplinary team composed of nurse midwives, nurses, educators, social workers, nutritionists and lay personnel participate in the program. Expected outcomes include: improved infant mortality, improved familial relationships, reduction in the number of repeat pregnancies, reduction of child abuse in this "at risk" group, improved parenting skills of both the mother/father, a decrease in the child developmental problems, higher rate of return to school or work, and improved self-esteem and positive self image. Results from the first eighteen months have been impressive. Seventy-eight percent of the 125 patients in the experimental group returned to work or school, compared with only 29% of the 125 in the control group.

- **Los Angeles County—High Desert Hospital's Easy Street Program**

The Easy Street Project is High Desert Hospital's solution to addressing two important issues: 1) the need for a training environment to prepare acute medical rehabilitation patients better for independent living, and 2) a low level of public awareness regarding High Desert Hospital and the hospital's Acute Medical Rehabilitation program. The project is based on the concept of providing a simulated community in which persons recovering from disabling injuries and diseases can relearn and practice the activities of daily living. The Easy Street Project has accomplished the following: 1) construction of a training center, and 2) raising $38,000 to purchase appropriate training modules. Patients use the training center daily as they strive to regain the skills needed to live on their own.

- **Erlanger's Tag-Along-Tots Program**

Tag-Along-Tots is Erlanger's solution to the day care needs of its volunteers. It has led to successful recruitment of home-bound mothers of preschool children and enhanced the effectiveness of the hospital's auxiliary. The tots enjoy such activities as singing, story time, art and creative play. They learn to share and play with other children. Not only do their mothers enjoy being productive members of the community, but the children learn that a hospital is not a place they need to fear.

- **Harbor-UCLA Medical Center's Volunteer Supported Electrocardiograph Program**

Because of an acute shortage of the technical staff necessary to provide various ancillary procedures, outpatients at Harbor-UCLA Medical Center often had to wait 3–4 hours for ECG testing. To meet the obvious need for technical staff, the Chief of the Cardiology Department determined that volunteers could be trained to perform ECG's. This was possible due to the fully computerized ECG system utilized at the Medical Center. Portable monitoring units are used at many locations and are linked to the central unit through telephone lines. The portable unit's results are displayed, on line, at the Central Heart Station. Immediate review of test results is available to ECG Technical personnel at the time the tests are performed.

The Medical Center's Volunteer Electrocardiograph Program is operated by ten volunteers under the direct supervision of the Cardiology Department's Heart Station. During 1989, over 2,800 ECG's were performed, resulting in approximately $156,800 in revenue. The hospital has saved approximately $48,000 per year since it did not hire the additional 2 FTEs that would normally be required to manage the workload of the volunteers.

- **Rancho Los Amigos Medical Center's Corrective Cosmetic Total Image Center.**

Teaching self-esteem to those who must learn to cope with a seriously altered physical appearance is the focus of the Corrective Cosmetic Total Image Center at Rancho Los Amigos Medical Center. Two components of the center's program involve paramedical cosmetics and school re-entry. Individuals are taught how to normalize their appearance thus facilitating and promoting employment. They also learn coping skills to assist them in living effectively in society. The School Re-entry program for burn injured children eases the transition of the child back into the classroom by educating the child's peers and teachers about burn injuries.

- **R.E. Thomason Hospital's Health Careers Apprenticeship Program: AHEC**

The Health Careers Apprenticeship Program at Thomason Hospital is designed to promote health care careers among Mexican American youth. The program provides summer employment for pre-med college minority students. Students serve as tutors, mentors and designers of healthcare curricula. The program not only creates an opportunity for minority students to pursue a healthcare career, but also promotes healthcare as the professional choice for thousands of students in El Paso.

- **Tampa General Hospital's GENESIS: A Health Center for Women and Children**

GENESIS was established in Tampa, Florida to reduce both the incidence of perinatal morbidity and mortality associated with high risk pregnancy and the number of children at risk for health and developmental problems. Early access to specialized medical care for women at greatest risk for complications of pregnancy is prioritized at the program. A coordinated, patient-oriented approach to outpatient and inpatient care is provided.

Services include: Outreach and case management, pregnancy testing and counseling, prenatal and postpartum care, family planning assistance and gynecological care, assessment of fetal well-being, well-baby and child health care, nutritional counseling, health education, social services, financial assistance and counseling, coordination of transportation, on-site child care, educational experiences for students of health care professions, and referral for women and infants at risk for poor pregnancy outcomes.

- **Queens Hospital Center's "A Community United Against Drug Abuse—Saving A Generation"**

The Queens Hospital sponsored a contest, "A Community United Against Drug Abuse—Saving A

Generation, " which attracted more than 600 Junior and Senior High School students. Students submitted essays detailing their perspective on drug abuse. A provocative dialogue resulted between contestants and Queens Hospital Center clinical and social work professionals in a panel discussion which formally ended the contest.

The contest's preventive approach had the successful outcome of stimulating thought among participating youth about the value of a drug free society. The contest, panel discussion, awards, a trip to the NY State Legislature, and publicity all supported the drug free message. The message was especially strong since it was delivered by students to students.

- **Erlanger's Families Supporting Peer Education Project**

Erlanger's Families Supporting Peer Education Project is an innovative approach to pass on factual information regarding substance abuse and human sexuality. It uses knowledge and role models to positively influence pre-adolescent and adolescent children. The program trained a small group of high school students to serve as role models for younger students. The high school students worked with 200 elementary students to help them understand that knowledge and a healthy life style can be taught and lived by them.

- **Goldwater Memorial Hospital's Health Careers Program for High School Students**

The goal of Goldwater Memorial Hospital's Health Careers Program for High School Students is to attract capable and motivated youth to the health-care industry. The target group is high school students attending public schools within the five boroughs of New York City. The program has established a partnership between specific high schools. Each high school has a health-career curriculum that informs students about possible health-care careers. The curriculum also consists of the students interning at the hospital during the school year. Attempts are made to direct students' efforts into helping patients' progress. Students spend time in specific therapies such as Occupational Therapy, Physical Therapy, Speech, Psychology and recreation; or, rotating in Pharmacy, Labs, Respiratory, Nursing, etc. Some of Goldwater's high school seniors have just been accepted into pre-medicine programs at various universities.

- **Erie County Medical Center's S.T.E.P. Program**

S.T.E.P. (The School to Employment Program) is a two part program that includes both "World of Work" workshops and on the job training. The program addresses the needs of twenty youths who are contemplating dropping out of school. The staff closely monitors the students, and evaluates each participant's basic education skills and vocational skills progress.

S.T.E.P. is designed to enhance the participants' self worth and to encourage responsibility in their personal activities and employment. A follow-up will be done on each participants' progress in school, as well as on the job, on an ongoing basis.

- **Truman Medical Center's Minority and Women's Business Enterprises Support Program**

Truman Medical Center (TMC), Incorporated has recognized the need to give substance to its public commitment to promote equal opportunity in procurement among all vendors of hospital goods and services. They have implemented a support program for local Minority and Women's Business Enterprises (MBE/WBE) and have succeeded in stimulating MBE/WBE vendors to seek business opportunities with the two TMC hospitals. In order to ensure a long range relationship is established, TMC, Inc. assists the vendors to become competitive. To date, more than one half-million dollars annually has been purchased from its MBE/WBE vendors, a positive beginning.

- **Pontiac General Hospital's Service with Love**

Pontiac General Hospital's concept of caring is embodied in their theme of "Service With Love." The theme is featured in all of their programs and provides "service with love" throughout the human life cycle: to the unborn through prenatal services for mothers-to-be who cannot afford private care; to the newborn through a unique parent/child bonding program in the Neonatal Intensive Care Unit; to active adults through a critical incident stress management program; to the elderly through a system of daily telephone reassurance calls; and to the mentally ill through a process of redirecting productive community interaction.

Development

- **Riverside General Hospital's "Development of Capital Financing for a 364-bed Replacement Teaching Hospital"** (Safety Net Award Winner, 1990)

In order to develop capital financing for the replacement of the antiquated 274,000 square foot county hospital with a state-of-the-art 487,000 square foot facility, at an approximate cost of $150,000, significant non-operating revenue that could be used for debt service had to be identified. Riverside developed resources through legislation, which became law in 1989, that provides Medi-Cal supplemental

reimbursement to pay debt service for borrowing associated with capital financing above $5 million. The reimbursement takes into account the proportion of the hospital utilized by Medi-Cal patients.

- **Erlanger Medical Center "The Professionals"** (Safety Net Award Honorable Mention, 1990)

Erlanger Medical Center has worked with National Health Enhancement Systems of Phoenix to develop "The Professionals." The Professionals is a state-of-the-art telemanagement system designed to establish personal relationships with targeted consumers and to influence their decisions in healthcare choices. The most important aspect of the program is that it allows operators to reach into the data base to pro-actively call consumers and conduct specifically designed outbound campaigns. To further enhance the program, new households in the area are sent a "Health Resource Kit" introducing the medical center programs and services. It also includes a postage paid card on which the newcomer can check-off the programs that interest him most and which, when returned, allows him to be entered into The Professionals' data base.

The program impacts Erlanger's role as a safety net hospital in three key areas: First, it provides access to healthcare information to under served individuals, thus reducing the number of unnecessary trips to the emergency department and outpatient clinics. Second, it provides access to physician and health service referrals to the under served, again reducing emergency department visits. Third, it provides Erlanger with a state-of-the-art, measurable marketing system which allows them to protect their commercially insured market share. It is this share that enables them to absorb the high cost of indigent care.

- **San Joaquin General Hospital' Food Service Program**

The thrust of a food service program managed by San Joaquin General Hospital's Dietary Department is to use existing resources to provide additional means of revenue. The program seeks to identify and develop sources of revenue in non-patient food service, specifically: 1) catering and contracting; 2) employee/visitor food service; and 3) community outreach.

The program has been successful in creating a safety net for the hospital because of increases in revenues, but it also has provided additional benefits, including: 1) improved patient and non-patient services and an increase in customer satisfaction; 2) improved departmental morale; and 3) a positive community image of the Dietary Department. The program has resulted in a more effective use of existing and available resources.

- **Rancho Los Amigos Medical Center's A. Estin Comarr Spinal Injury Clinic**

In 1979, a nurse practitioner-managed primary care clinic was initiated specifically to provide comprehensive, cost effective outpatient care to persons with spinal injury. Prior to the opening of this clinic, fragmented care often resulted in either costly inpatient readmissions or emergency department services. The clinic was able to provide holistic, case managed care that focused on health promotion and maintenance as well as primary medical care for acute needs. Nurse practitioners assisted patients with accessing vital community resources.

In 1983, the clinic was expanded to incorporate other specialized spinal injury clinics and therapy services. It now provides a single location for all spinal injury outpatient services at Rancho Los Amigos Medical Center.

- **Rancho Los Amigos Medical Center, Center for Applied Rehabilitation Technology (CART)**

An interdisciplinary team of professionals works together at Rancho Los Amigos Medical Center's Center for Applied Rehabilitation Technology to determine the ability of patients to use state of the art technology in all daily life activities. The Center offers training to the patient, family, and other professionals in the use and management of recommended equipment. They also provide, as necessary, the follow-up support required for the maintenance, upgrading and modification of equipment. CART serves as a source of additional referrals for patients, parents, and professionals.

- **Queens Hospital Center: Hypertension Counselling and Screening Program**

Queens Hospital Center initiated creative strategies to prevent and control cardiovascular disease among its patient population in South Jamaica, New York. The program consisted of the establishment of several community-based high pressure screening and counselling sites known as the "Pressure Point Sites." To gain greater visibility in the community, and to expand outreach, the program obtained the use of a van and driver from the New York Telephone Company. This resulted in street-side hypertension screening. Further expansions included a series of workshops on Cardiovascular Disease Prevention and a "Culinary Kitchen" course teaching healthier cooking.

The Program has successfully screened 3,800 people, and participants who receive medical care at the satellite clinic have improved blood pressure control and lower cholesterol levels.

- **Rancho Los Amigos Medical Center's In Home Supportive Services Training Project**

Rancho Los Amigos Medical Center has implemented a training program for social workers in the county of Los Angeles Department of Public Social Services' In Home Supportive Services Program. These social workers determine how much attendant care will be funded for clients after discharge from the Medical Center. The training provides information on the home care needs of the physically disabled and assists in accurate assessment of each client's needs. Such training will prevent the misuse of vital health care resources.

- **Truman Medical Center's Medicaid Managed Care Program**

In 1984, Truman Medical Center began contracting with the State of Missouri as a provider of health care on a prepaid basis to Medicaid AFDC recipients in Jackson County. For the first three years, the managed care program operated as a federal demonstration project in which the state contracted with health plans to provide Medicaid-covered services with a capitation payment mechanism. In order to continue the program after the initial period, Truman Medical Center pursued state HMO licensure that was required for participation in the program. It was received January 1, 1987, enabling the plan to continue serving 11,000 AFDC enrollees, 41 percent of those eligible in the county.

- **Tampa General Hospital's Community Health Council**

Concern over Tampa General Hospital's restructuring into a 501(C)3 corporation led to the formation of a group to look at health care issues and maintain a dialogue with the community. The Tampa General Community Health Council is representative of the community and contributes to community awareness, understanding and support for Tampa General and its mission. Its goals are to facilitate public health education, contribute to the development of public health policy, serve as a community liaison group especially knowledgeable about Tampa General and related issues, and provide a forum for discussion with cosponsors with the community to host seminars or other programs.

- **Erie County Medical Center's Rural Health Initiative: A Demonstration Project Between A Large Urban County Hospital and Four Rural Hospitals**

In an attempt to make high quality comprehensive physical medicine and rehabilitation services available to rural communities, the Western New York Rural Health Care Cooperative was formed. It has combined the expertise of a School of Medicine, Department of Rehabilitation, Erie County Medical Center, and their access to a consortium of urban in-patient rehabilitation programs with a Cooperative of rural hospitals.

Start up funding has been sought from HCFA. The program would offer the opportunity to develop a system with linkages for the most intensely specialized rehabilitation unit located in urban centers to the less intense out-patient program readily accessible to the rural communities of Western New York. The potential for continuity of care is obvious and the predetermined linkages would allow for efficient movement to the appropriate level. This in turn would allow for efficient use of health care dollars at a time when the ever escalating cost of healthcare is a constant concern.

- **Los Angeles County—High Desert Hospital: High Desert Hospital Strategic Plan**

As a result of dynamic population growth in the communities served by High Desert Hospital in Los Angeles County, the hospital faces many new challenges and demands. Recognizing the need to plan for these changes, the Administrative and Executive Staffs initiated the development of a five-year strategic plan.

Through a series of planning retreats, a five-year vision was established. The six key strategic directions that were developed are: 1) to expand the existing facility or construct a new facility; 2) to explore medical school affiliation; 3) to promote a positive image of High Desert Hospital; 4) to build a strong financial base; 5) to maintain a qualified work force and provide an environment that promotes professional growth and job satisfaction; and 6) to assure the accessibility and quality of personal health services. For each strategic direction, specific strategies were developed, and members of the steering committee were given responsibility for developing plans of implementation.

- **Erie County Medical Center's Physician Care Management Program**

The Erie County Medical Center has coordinated the development of a voluntary association of internists, pediatricians, and family practitioners to provide primary care services to eligible clients on a prepaid capitation basis. The physician group will provide managed health care while reducing overall Medicaid spending by reducing the costly use of inappropriate clinic/OPD and emergency rates.

The primary care physician will be responsible for managing, coordinating and controlling the patient's utilization of services. The primary physician will refer the patient to specialty physicians, and these

practitioners will be reimbursed on a fee-for-service basis.

- **Medpride at the Med: The first "family" campaign for the Regional Medical Center at Memphis. May-June 1989, May 11, 1990**

The first ever "Family" fund raising campaign for The Regional Medical Center at Memphis (THE MED) was a total success. A total of $85,000 was pledged, far exceeding the goal of $55,175. $70,000 was pledged by employees at THE MED.

- **San Joaquin General Hospital's Health Care to Families of Employees**

San Joaquin General Hospital has enhanced revenue for the hospital by attracting the families of 10,000 San Joaquin County insured employees, dependents and retirees. The program provides quality, accessible outpatient health care in two locations, one located at the hospital and one located in the heart of downtown Stockton. The hospital provides all inpatient services.

The program has resulted in a financial safety net for the hospital due to the rapid growth of patient utilization which has generated increased revenue. Other benefits to the hospital have been increased general awareness of services provided to the community and the ability to improve access and services to the targeted group.

12

The Future of Safety Net Hospitals: A Policy Agenda for the 1990s

The information and analyses in this White Paper illustrate with precision the immense problems faced by America's safety net hospitals. Yet they also point to gains made over the last several years, as well as to significant opportunities for the future.

Chief Among Recent Gains Is the Simple Recognition by Many Federal, State and Local Health Leaders That Our Nation Does Indeed Possess an Institutional Health Safety Net.

Coupled with this hard won recognition is the equally important realization that this safety net is a fragile one, which must be supported and preserved. The term "disproportionate share hospital" (DSH) is perhaps an inartful one, but it has now taken on real meaning in the Medicare, Medicaid and other health programs, with billions of dollars paid to DSH hospitals each year through reimbursement adjustments. Capital access programs like the FHA Section 242 Hospital Mortgage Insurance have also been opened up to public hospitals in the last several years. (The FHA program has now been used successfully by a major urban public hospital, Boston City Hospital). Funds for hospital trauma care, and for the medical care of special populations such as legalized immigrants and AIDS patients, have now been authorized by Congress, although appropriations remain a constant battle with these new programs.

Despite these gains, the needs of America's safety net hospitals, and the patients they serve, remain great. It is imperative that policy-makers continue to respond to those needs at all levels of government over the next several years. NAPH member hospitals strongly believe that both comprehensive and incremental reforms and initiatives will need to be considered, discussed, and enacted during that period. NAPH's observations and proposals as to the scope and content of those reforms and initiatives are outlined and briefly described in the remainder of this chapter.

Universal Access to Health Coverage Must Be Guaranteed to All Americans by the End of the Coming Decade.

Universal health coverage must remain the single most important legislative and policy goal of our nation's health system. To be truly effective, NAPH members believe that a nationwide program is an essential component of genuine health coverage reform. Unfortunately, thus far the federal government has not taken the lead in achieving this goal, continuing instead to abdicate this leadership role to the states. Moreover, future prospects at the federal level are not encouraging, in light of such factors as the size (and growth) of the projected federal deficit for 1991 and 1992, as well as the demonstrated willingness of the Congress to abandon reason and sound policy in the face of the increasingly strident, well-organized and ever-growing elderly population.

On the other hand, there has been a high level of activity and discussion in a small handful of states—such as the trailblazing actions of Hawaii and Massachusetts. But Hawaii's requirement for universal coverage benefits greatly from that state's geographic and economic isolation, as well as from a hard-to-replicate ERISA exemption that permits the state to regulate self-insured employers. In addition, while ambitious in concept, the Massachusetts experiment now appears very close to being dismantled.

Several states, like the state of Washington, have recently enacted more limited risk pools or other demonstration programs which are intended to apply initially only to certain parts of the state, or to subgroups within the population. Other states, like California, New York, Michigan, Illinois and Oregon, have ambitious proposals in the hopper, but with no clear indication of a timetable for enactment. All in all, while there is considerable discussion of states becoming the laboratory for a universal health coverage plan, their performance to date has been disappointing. Moreover, the combination of sobering deficits and newly elected governors in many states will probably keep many state proposals on a slow track.

Given this track record, it is perhaps understandable that NAPH member hospitals as a group are relatively pessimistic about the short run prospects for achieving universal coverage at the national level, or in many states. NAPH members remain convinced that incremental reforms at best will be achievable for most of the 1990s, and that efforts should be concentrated in that direction. However, in keeping with the spirit of those health industry leaders and legislators who are still willing to push for system-wide reform, NAPH is pleased to set forth the essential criteria for a national health plan. The following principles, at a minimum, have been endorsed by NAPH member hospitals as essential to any national health plan:

- While incremental improvements are acceptable in their own right, the goal of any national health

plan must be nothing less than universal access or coverage for all.

- However, not every individual needs to receive **insurance** coverage to be guaranteed true access under a universal health plan; it must be recognized that there will always be individuals who fall through the cracks, and that it is acceptable to provide access for such persons through the preservation of a strong and well-financed **institutional safety net**.
- A national health plan must require the federalization of the Medicaid program, and quite possibly its elimination and merger with Medicare.
- A core national minimum benefit package must be developed that is not too rich as to be unaffordable, yet covers essential preventive, primary care and hospital services, and guards against the prospects of catastrophic illness.
- The present system of private insurance can continue under a national health plan, but insurance reform is an essential part of any national health package; the federal government should preempt state regulation to the extent necessary to set national standards for health insurance plans, which include mandating minimum benefit packages on all employers above a reasonable size, reinstatement of community rating, and curbing current trends toward exclusion of preexisting conditions (or setting post-illness limits on specific diseases such as AIDS).
- States must be permitted wider latitude to experiment with new plans, including the ability to waive ERISA constraints on the regulation of self-insured businesses.
- Any national plan must include a heavy emphasis on preventive and primary care and must provide adequate support for initiatives to encourage changes in lifestyles.

Unless and Until Universal Coverage Becomes a Reality, Continued Efforts Must Be Made to Reform the Medicaid Program.

Recent improvements in the Medicaid program have expanded eligibility for pregnant women and children, permitted states to continue using a variety of mechanisms for providing extra payments to disproportionate share hospitals, and permitted public and private hospitals to participate in the financing of Medicaid expansions through voluntary donations and the transfer of funds by local governments to states. In addition, states like Florida, New York and New Jersey have used provider taxes or all-payer systems to redistribute revenues and enhance Medicaid payments. **It is imperative that states be permitted to continue to make use of these alternative sources of revenues, at a time when many are suffering severe budget crises.**

Unfortunately, not every state has implemented all new federal mandates to date. In particular, many states have essentially ignored the mandate that they pay a meaningful adjustment to hospitals that serve a disproportionate number of low income patients. Even with the availability of the augmented payment sources described above, only about half of all states pay significant differentials to "disproportionate" safety net hospitals. And a number of states continue to subject hospitals to inadequate base payment rates as well, as is evidenced by the proliferation of lawsuits brought by hospitals against state Medicaid agencies around the country. **Both reasonable and adequate Medicaid payment rates, and meaningful disproportionate share hospital payments, must be enforced upon all states.**

Medicaid **eligibility determination** is another area where there is substantial room for incremental reform. It has been estimated that over half of potentially eligible Medicaid recipients in many states never actually become eligible because of unsurmountable procedural obstacles. The Medicaid eligibility process should be streamlined, and consistent standards developed.

With respect to other reforms, the biggest obstacle is the fact that the Medicaid program today is cursed with a decidedly uneven playing field. States suffering severe fiscal crises essentially contain costs and "manage" their programs by squeezing down on whichever constituency is weakest. This is why we have such disparity among Medicaid programs today—

—why some states have broad eligibility and benefits, but poor provider payments

—why others pay hospitals well but pay physicians poorly, or pay all providers well but cover few eligibles, and

—why a new rationing proposal like Oregon's can be put forward with a straight face in the name of "reform."

What is an "Oregon Transplant"? One thing is certain: it is not taught in medical schools (at least not yet). Simply put, it is any procedure performed for an Oregon Medicaid recipient who has "transplanted" herself to a hospital in a neighboring state because Oregon will no longer pay for her care.

Whatever else you may call it, Oregon's Medicaid rationing proposal is audacious. The core of the proposal, which will require a hotly contested federal waiver, is a three part formula designed to rank 1600

medical procedures from "most" to "least" beneficial. Numerical scores are assigned to each procedure on the basis of cost, benefits (measured in number of years of life following the procedure), and "quality of well being"—how the patient feels after the treatment. For example, outpatient antibiotic treatment for infection ranks very high on the list, while virtually any service provided to a dying patient (other than those intended to make him more comfortable) ranks quite low.

Each year, depending on funds available, procedures will be "covered" (i.e., paid for) from the top of the list down, until the money runs out. As a practical matter, patients in need of procedures with low scores are highly unlikely to receive coverage in any year, at least in Oregon. An interesting sidelight of the plan is a provision that shields providers from malpractice liability for treatment decisions based on Medicaid's failure to reimburse.

Other features of the proposal include an expansion of eligibility to include all women and children up to the poverty level and a requirement for managed care. Unrelated to Medicaid, the plan also increases employer mandates, with possible subsidies for small employers (although like all employer mandates, these are likely to be ineffective as long as the Federal ERISA law continues to exempt self-insured companies.) Long term care is not touched by the proposal, and the elderly and disabled are also exempted.

As bold as it is, the Oregon rationing plan is badly flawed. State officials readily admit that their initial "cost-benefit" methodology was a disaster, and the publication of their initial rankings of procedures gave much ammunition to opponents. But the flaws in Oregon's proposed plan run considerably deeper than that:

- Their requested waiver applies to all Medicaid services, which would leave recipients not knowing from year to year whether even the most essential mandatory services are going to be covered.
- The annual reevaluation of services on the basis of "available funds" will leave providers as well as recipients in the dark, making capital planning for high volume Medicaid providers a virtual nightmare.
- Exempting the elderly and disabled will concentrate the impact of the plan on poor women and children—the most vulnerable Medicaid population and the one group with no access to Medicare or other support.
- The waiver proposal leaves wide open the possibility of unacceptable and unaffordable levels of cost sharing for poor women and children, and the "managed care" aspects of the plan could lead to serious but unspecified reductions in recipient access to a reasonable number of providers.
- Proposing to use service cutbacks for some women and children to increase coverage for others may sound noble —but because of procedural barriers, Oregon is not even signing up all of the eligible women and children under their current program. (In 1988 alone, according to a national survey prepared for the Southern Governor's Conference, nearly 14,000 potential recipients had their applications rejected by Oregon—nearly two thirds of them for failure to comply with the program's procedures.)
- Oregon's new approach also takes the state off the hook, at a time when raising more revenues may be a more reasonable alternative and reforms that affect more than just the Medicaid program could lead to more permanent health system improvements. Certainly, broader health system changes are likely to be more equitable than reducing Medicaid services for mothers and babies.
- Finally, while all of the rhetorical flourishes are there, Oregon's proposal does not in fact address the rationing of **CARE**—just the rationing of **PAYMENT**. Oddly enough, Oregon providers appear to support this initiative. Yet it does not deal in any meaningful way with the pressures that will remain on them to provide services whether or not they are covered. For despite the program's curious malpractice "waiver", the fact that some providers may have relatively easy choices (e.g., whether or not to provide an organ transplant) may well obscure the fact that many of the procedures for which payment may be denied under this plan are far less discrete, particularly if a spell of treatment is underway for a patient with a questionable prognosis or multiple diagnoses.

As flawed as Oregon's current proposal may be, it is clearly pushing the right buttons, addressing the right issues. And lest a dozen or more Oregons spring to life as soon as that state has acquired its waiver, we must use this opportunity to prod our national and state leaders to a nationwide reform and restructuring.

We need not await the enactment of national health insurance to reform Medicaid. There are many important steps we can take today. They include new outreach efforts, coupled with procedural reforms, to ensure that we are signing up all those who may be eligible now; efforts to fill in existing gaps that will mandate a solid core of eligibility standards, benefits and payments; and a decoupling of long term care from the rest of the Medicaid program, so that needed attention can be paid to both sides of this mismatched equation.

The Trouble With Rationing

The supposed necessity of rationing rests on the assumption that no other expedient can prevent for long the continued escalation of health costs. Advocates of rationing usually acknowledge the growing evidence of overuse of services, inefficient use of facilities, and excessive overhead and administrative expenses. They may even accept the proposition that substantial elimination of such defects might reduce the cost of health care by as much as 20 or 30 percent. But they maintain that any reforms of this kind would produce only a one-time savings that would soon be nullified by a resumption of the inexorable rise in costs.

This argument, its seems to me, fails to recognize the crux of the problem. New forms of technology and insatiable demand are not the fundamental causes of cost inflation, nor are overuse, inefficiency, duplication, or excessive overhead expenses. They are simply the manifestations of a system that has built-in incentives for waste and inflation. It is the way we organize and fund the delivery of health care that rewards the profligate use of technology and stimulates demand for nonessential services; it is the system that allows duplication and waste of resources and produces excessive overhead costs. Change certain features of the system, and you will not only reduce costs in the short run, but moderate the inherent forces causing inflation.

Arnold S. Relman, M.D.
The New England Journal of Medicine
September 27, 1990

The Medicare Disproportionate Share Hospital and Medical Education Adjustments Must Be Preserved and Increased.

Medicare, as the data in this White Paper shows, is a relatively smaller proportion of the patient load in safety net hospitals than in the rest of the industry (only 19%, as compared to 34% on average for the industry as a whole). However, it is usually the single most important **non-indigent** payer in many safety net hospitals, and as such, constitutes an essential part of patient care revenues.

Great strides have been made in mandating Medicare payment adjustment increases for "disproportionate share hospitals." This program has grown from paying just $200 million in its first year to well over $1 billion in 1990. In the last two years, Congress has also refrained from making any further reductions in the indirect teaching adjustment. This has resulted for the first time in actual real dollar gains in Medicare reimbursement for safety net hospitals, although this has not succeeded in erasing the significant operating deficits of such hospitals (such deficits currently average over $9 million, or −6%).

Ironically, these real gains have also resulted in the Medicare disproportionate share adjustment coming under fire for the first time in the legislative process. In particular, it was argued in the 1990 reconciliation act debate that "it is not the role of the Medicare program to finance care for the uninsured." However, this debate actually proved to be positive for safety net hospitals, in that it gave legislators an opportunity to state clearly that Medicare **does have a continued role in financing uncompensated care**, along with all other payers—at least until such time as our nation achieves universal health coverage!

In other words, the survival of safety net hospitals is **as important to the Medicare program** as that survival is to the health of their indigent patients and the fiscal viability of the rest of the hospital industry.

Finally, with respect to Medicare, the last several years have also seen efforts to recoup significant amounts from safety net hospitals and other providers in several areas **by changing reimbursement rules and then attempting to apply those changes retroactively**. This has now occurred in the last three years with Medicare bad debt payments and with Direct Medical Education payments. In both cases, the Congress has intervened on the side of safety net hospitals to deter or mitigate the effect of these efforts—but considerable additional vigilance in this area will be called for in the next decade.

Direct Institutional Support for Safety Net Hospitals Must Become An Immediate Federal Priority.

While Medicare clearly has a role to play in sharing the financial burden of safety net hospitals, it is also true that additional interim measures are needed. In particular, as the debate over universal health coverage drags on, it is imperative that the Congress enact some form of **nationwide institutional support for safety net hospitals**.

Ideally, this should take the form of a national uncompensated care trust fund, with dedicated sources of revenue. A bill originally developed by Representative Pete Stark (D-CA) with the assistance of Dr. Max Michael of NAPH member Cooper Green Hospital and NAPH, could serve as a model. That legislation, which was first introduced in the 99th Congress, would create a trust fund with the proceeds of a small tax on health insurance premiums; such a tax could potentially generate $600 million for high volume providers of uncompensated care. Other potential funding sources include taxes on alcohol, tobacco, firearms, and a national excise tax on hospital utilization.

A New National Capital Financing Initiative Is Needed to Rebuild and Equip America's Institutional Health Safety.

The staggering need for, and barriers to, capital access for public hospitals has been described in Chapter 10. In order to meet these needs and rebuild America's health safety net, several new programs could be provided; ideally these programs should be administered through a single entity. Capital financing options under such an initiative might include such vehicles as direct federal grants and loans, debt service subsidies, and targeted credit enhancements such as mortgage or bond insurance. Like the Hill-Burton program, it is anticipated that in exchange for financing assistance, hospitals must agree to meet long-term indigent care and community service requirements, and perhaps other reporting and utilization requirements. Unlike the Hill-Burton program, however, support under this new programs should be limited to those urban and rural institutions whose missions and lack of access to capital can be clearly demonstrated.

The Indigent Care Role of the Private Hospital Sector, and Other Health Care Providers, Must Be Clarified and Strengthened.

The need for health services by uninsured patients continues to escalate dramatically—and the predicted recession can only increase this demand. At the same time, due to competitive and reimbursement pressures, many private hospitals (and other providers) have aggressively sought ways to reduce services to uninsured safety net patients. Quite simply, the willingness and ability of private providers to shift the costs of uncompensated care to privately insured individuals have been significantly eroded in recent years.

Emergency department closures—trauma center decertifications—the abandonment of high risk tertiary services—the curtailment of outpatient services—these private sector actions have increased pressure tremendously on safety net providers.

For example, the closure of several private trauma centers in Los Angeles County has put a tremendous strain on county emergency services. The demand by low income patients for obstetric services is so high in L.A. County (and the availability of private alternatives so low) that some county hospitals have instituted a 12-hour length of stay for many cases. The waiting time for all patients in county outpatient specialty clinics—often the only specialist services available to any low income patient—is now up to 4-6 weeks. The county system is quite literally stretched to the very margin of its ability to cope. Yet if it cannot continue to do so, if L.A. County should close or substantially curtail many health services, it would spell disaster for the entire Los Angeles County health system.

What then is the role of the private sector in helping to guard against this disaster? Policymakers at both the federal and state level have been increasingly asking this question, in light of the substantial tax benefits provided to many nonprofit hospitals (as well as the substantial Medicare and Medicaid spending bestowed upon both non-profit and for-profit facilities). Nationally, members of Congress and officials of the Internal Revenue Service have been reassessing possible requirements for hospitals wishing to maintain a tax exempt status. In addition to tax status, the Congress has also been taking a more careful look at (and increasing penalties for) the involuntary transfer of unstabilized patients.

At the state and local level as well, governmental entities have been carefully scrutinizing the activities of private hospitals. In Utah, for example, a state Commission has recently established new guidelines for hospitals that wish to be exempt from property taxes. Those guidelines include making healthcare available to all persons regardless of ability to pay, and a measurement of a hospital's charitable "gift" to the community in terms of the amount of taxes that might otherwise have been paid by the institution.

All of these trends are positive ones and should be encouraged by safety net hospitals, if only to counterbalance the economic and competitive trends that are causing private providers to abandon their commitment to the poor. But safety net patients should not have to rely on the grudging enforcement of legal rights in private hospitals. There remain adequate revenues overall in our nation's health system to permit private providers to pitch in and assume their fair share of the indigent care burden, which in turn will alleviate the pressures and enhance the survivability of the safety net. At the same time, safety net hospitals must continue to educate private employers and insurers about the importance (for now) of permitting at least a certain amount of cost shifting to continue to finance the provision of such indigent care.

State and Local Elected Officials Must Become More Proactive in Support of Their Safety Net Hospital Systems.

As the data in this White Paper illustrate, many local governments (and some states) play a significant, direct role in subsidizing the mission of safety net hospitals. Nationally, it has been estimated that counties and other local governments contribute upwards of $12 billion annually to subsidize direct

patient care for the uninsured poor. One recent study found that cities or counties in 54 metropolitan areas contributed an average of over $30 million each to indigent hospital care.

For these reasons, it was extremely disturbing to hear arguments made during the FY 1991 budget reconciliation debate that federal funding should not be increased for government-owned hospitals and other publicly funded safety net providers, on the theory that "such an increase would simply replace state or local funding sources." While such arguments have always been raised by Congressional conservatives opposed to support for state or local domestic programs, they were also made this year by some segments of the private hospital industry as well.

The particular target of this campaign against safety net hospitals was the House-passed proposal to increase the Medicare urban disproportionate share hospital adjustment by $2.2 billion over the next five years. Ultimately, the conferees agreed to accept an increase of $1 billion—but not without a lengthy and acrimonious debate. This was one of the last issues resolved in the 1990 OBRA conference (ultimately, an additional $1 billion also went to rural hospitals as part of this compromise.)

What is especially worrisome is that this argument made by private hospitals, which was taken at face value by many legislators, is simply wrong. For most urban public safety net hospitals, maintaining and increasing direct local spending has been as essential to survival as the few increases that have been achieved at the federal level. In most urban areas, as this White Paper clearly shows, direct city, county (and in some cases, state) subsidies have in fact continued to increase substantially in recent years. For this reason, such an argument is an insult to the many local elected officials who work so hard each year to improve funding for essential health services.

Clearly, a greater awareness is needed of the essential role of local government in supporting our nation's health safety net. The billions of local tax dollars that pour into this system are its life blood—the foundation of support without which the rest of the system could not function. In the forthcoming 102nd Congress, it is imperative that this message be delivered effectively.

The Voice of Local Elected Officials Must Be Strengthened, It Is Incumbent on All Local Officials to Educate the Public, Their Representatives and Senators—and the Private Hospital Industry.

Elected officials must make clear that local governments are not "another special interest group," but are rather the true partners of the federal government in the effort to meet the vast needs of America's uninsured and underinsured citizens.

Finally, Safety Net Hospitals Must Prepare to Change the Way They Do Business in the Future to Preserve and Enhance Quality—To Improve Efficiency—To Attract Medical, Nursing and Administrative Staff—and To Engage Effectively in Managed Care Programs.

It is essential that safety net hospital officials take careful stock of their own strengths and weaknesses, including their administrative efficiency and the quality of care they provide (or are perceived to provide). It would be a great irony if the strongest advocates of the uninsured—of integrated systems of primary and inpatient care—of highly organized medical staffs—were to succeed in achieving some form of universal health coverage, only to find that the remaining patient base in these facilities is inadequate to justify their continued existence.

It is clearly true that we do not need all of the hospitals that operate in America today, and that many hundreds of hospitals could probably be closed with little or no impact on quality or access to care. But, as this White Paper clearly illustrates, that simply cannot be said of America's safety net hospitals, whose closure would spell disaster in many parts of the country. As the United Hospital Fund's Bruce Vladek has said, "a full hospital never closes."

However, it is sometimes said that if national health insurance were to be enacted tomorrow, there would be no continued need for many safety net hospitals, especially public hospitals. Indeed, a more rational utilization of resources (including the closure or conversion of many acute inpatient facilities) will be an essential component of any universal health plan. But to suggest that safety net hospitals would be the most appropriate facilities to close, is to fail utterly to understand both the multifaceted importance of these hospitals, and the likely state of our nation's health system even following the enactment of universal health coverage.

First, it is important to note that many of America's safety net hospitals are vitally important to their communities and their regions for many reasons, including but by no means limited to their care for the uninsured. Medical education, high technology tertiary services, extensive outpatient services, trauma care, integration of preventive and environmental health services with acute care delivery, all of these functions will continue to be needed—and many will continue to be under-reimbursed, even by a universal system.

Second, it is important to recognize that any major new health insurance or coverage plan would almost certainly be designed around a fairly limited benefit package, with substantial cost containment efforts included in provider payment methodologies; for this reason, it is unlikely that patients insured under such new plans would be any more attractive to hospitals than Medicaid patients are today (and even Medicare patients are beginning to find their choices narrowing).

Third, there will always be people who fall through the cracks, no matter how comprehensive a plan is in theory. And under most of the universal health coverage and access scenarios, the need for a continuing institutional safety net is clearly envisioned.

Fourth, safety net hospitals quite simply often provide the best, highest quality medical care in their communities, with medical staff drawn from the faculties of prestigious medical schools; in many areas, the physical plant and ambiance of the hospital even permits aggressive and successful competition for privately insured patients today.

Still, while the need for most safety net hospitals will clearly continue even with the enactment of a "universal" coverage or access plan, the survival of those hospitals will clearly be in greater danger than they are even today if patients with their newfound coverage do not use these facilities. For this reason, it is imperative that safety net institutions that intend to survive pay careful attention to issues such as quality, productivity, efficiency, and managed care—as well as to their image.

Quality of Care and Quality Improvement Will Be Essential to the Future Success of Safety Net Hospitals

Quality of care has always been considered an important facet of hospital care. Yet even with its continued importance, measuring quality has remained elusive, while the concept itself has often remained isolated from delivery of services.

Recent efforts by the federal government, accrediting organizations, payers, foundations and others are changing the way hospitals and health care providers consider quality. Now, such initiatives as Total Quality Management, Medical Outcomes, Quality Improvement and Patient-Centered Care are attempting to make measurements more objective and make quality a central part of rendering care.

Monitoring and working to improve patient quality is fundamental to the role and mission of public hospitals. In addition to striving to provide the best care, these institutions look to the citizens in their communities for advocacy and for financial support. Although they serve as the safety net, the services they offer are available for all in their communities. As they attempt to reach out to poor and non poor alike, the level of quality will be a key factor in many patient decisions about where to receive care.

The recent quality of care initiatives have applicability to public hospitals as they review and refine their approaches. While patient satisfaction assessments have been traditional tools, hospitals should consider new techniques that quantify responses more objectively. For example, replacing questions like, "Did you like your physician?" with "Did your physician explain your medications to you?" "Did your physician explain discharge procedures and expectations?", will provide much more detailed information on how well a hospital is meeting patient needs. These and other measurements must also be sensitive to the unique and varied characteristics of the patient population served in public hospitals.

It is important to sensitize staff to the perception of patient care as including the essential components of attitude and responsiveness as well as technology and procedure. Linking medical outcome measurement to quality and incorporating these components can be considered part of that process. Finally, perceiving quality of care as an evolving component of service delivery is fundamental to making quality an integral part of hospital operation.

Managed Care Is Another Area of Health System Reform for Which Safety Net Hospitals Must Clearly Organize and Prepare.

While the growth of managed care has been slower and more fragmented than its advocates had originally hoped, there has been steady growth in recent years. In addition, HCFA under the Bush administration has now wholeheartedly endorsed "managed care" programs for Medicaid recipients, and many states appear to be interested. Indeed, for certain categories of both the Medicaid and non-Medicaid poor, the preventive aspects of managed care (and the potential for improvements in health status) may make a good deal of sense. Safety net hospitals must therefore look carefully at some of the public and private sector models that have been developed in this area, and seek to isolate the common elements of successful programs and determine their potential replicability. Successful public sector programs exist at the present time in California, Minnesota, Arizona, New York, and Florida, among other places.

Our Nation's Great Safety Net Hospitals

In conclusion, the situation of many of our nation's essential safety net hospitals has changed (for the worse) during the last decade. However, the data and

analyses presented in this White Paper clearly demonstrate that the importance of these institutions has remained great, and even increased, during this period. How can we best preserve the ability of safety net hospitals to carry out their collective mission?

Whether from Medicare, Medicaid or other programs, the number one priority of safety net hospitals continues to be adequate funding, both for day to day operations and for needed capital to rebuild. Despite modest improvements in a few areas, this goal has become increasingly difficult to meet in the last several years, and 1991 shows no promise of improvement. In addition to a gigantic federal deficit and a nationwide economic recession, states are anticipating a combined deficit exceeding $10 billion this year (and unlike the federal government, many states are constitutionally obliged to balance their budgets each year). Moreover, the budgets of many cities and counties are in similar shape. Clearly, the maintenance of the mission and services of safety net hospitals in the 1990s will require dramatic and imaginative initiatives. Those initiatives will both redirect existing revenues and develop new funding sources. They will both expand coverage of patients and provide direct support of safety net institutions.

The alternative to finding new revenue sources or redirecting existing ones may well be increased rationing. But as Dr. Arnold Relman has pointed out in his excellent *New England Journal of Medicine* editorials on that topic, rationing can only work if it is "personalized" for each patient, and if the rules apply equally to all patients, not just to subcategories of the poor. "When medical resources are uniformly limited for all, physicians can ethically and in good conscience allocate services to the patients most likely to benefit." (*New England Journal of Medicine*, September 27, 1990, at 913.) It is of course inescapable that safety net hospitals must already make many "personalized" rationing decisions every day in their emergency rooms and trauma centers. But NAPH agrees with Dr. Relman's view that formalizing and institutionalizing such a system would be "almost impossible"—both medically and ethically.

Like Dr. Relman, NAPH also believes that such draconian steps should not be necessary in a health industry that now rakes in over $600 billion annually—over $2,600 per year for every man, woman and child in the nation. With some economists predicting a doubling of that number by the year 2000, we can easily afford the kind of cost containment and revenue shifting initiatives that will permit us to maintain and rebuild our nation's institutional safety net—and at the same time fill in many of our coverage gaps.

Despite the grim fiscal picture facing safety net hospitals in the 1990s, not all of the changes of the 1980s have been negative. Consider the following bright spots among the recent activities of these institutions:

- The nation's increased emphasis on primary and outpatient care has drawn considerable sustenance from the models (and training programs) presented by this segment of the hospital industry. Safety net hospitals have always served as "primary caregiver"—family doctor—for many of its patients. The reader need only recall that **nearly seven million uncompensated outpatient visits** were provided in just one year by just 56 safety net hospitals. Some individual hospitals see over 500,000 outpatients per year. Clearly, most safety net hospitals are well positioned to respond to this trend in the future.

- Some safety net hospitals have been effective in gaining access to capital in unusual and creative ways. Boston City Hospital is the first major urban public hospital to make use (pursuant to an NAPH amendment) of GHA hospital mortgage insurance. Riverside (County) General Hospital spearheaded a drive to develop a Medicaid capital pass-through for DSHs in California and also used private sector creativity to build a new facility. Jackson Memorial Hospital and the NYCHHC (among others) successfully used revenue bonds, backed by private sector credit enhancement, for new construction and capital equipment (respectively).

- With increased attention to managed care, it is also now clear that this trend will be well suited to the mission and needs of many safety net hospitals. Because of strong ties to medical education, such hospitals already typically have an organized, integrated, high quality medical staff, including many salaried physicians. Effective public sector managed care programs have now been developed in California, Minnesota, Massachusetts, Florida, New York and elsewhere.

- Many safety net hospitals are also now reaching out to take advantage of the trend toward integrated health systems and regional networks. Jackson Memorial Hospital has become the core of a regional network that extends well into the Caribbean, in addition to covering a significant part of South Florida. JMH has even acquired facilities from for-profit providers in the process. Westchester County Medical Center is reaching out to develop affiliations with troubled nonprofit hospitals in its region—seeking to keep the doors of those hospitals open and hoping to alleviate its own overcrowding in the process. Los Angeles County has reached out to subsidize trauma care, on an interim basis, in private facilities. Parkland Memorial Hospital has established an extremely innovative Comprehensive Outpatient Care network of public and private providers. And the list of safety net innovators in this area continues to grow.

In the final analysis, the ability of safety net hospitals to survive and innovate in the 1990s will depend on the energy, creativity and dedication of their staff. In a 1987 JAMA editorial entitled "OUR NATION'S GREAT PUBLIC HOSPITALS", NAPH's senior officers said:

> ". . .with regard to the quality of public hospital staff, it must be noted that despite the many physicians who no longer practice in the public hospitals that trained them, many outstanding medical and administrative personnel, who could just as easily find more lucrative positions elsewhere, nevertheless remain to serve in such hospitals. These individuals, as a group, are quite possibly the finest and most dedicated health care professionals in the nation. With their continued dedication, and witih the strong support from those public and private health care decision makers who recognize the urgent need for these institutions, our nation's great public hospitals can continue to fulfill their vital mission." (Gage & Andrulis, JAMA, April 10, 1987; see reprint in Appendix B).

Those words remain true today. And right alongside rebuilding the safety net, and developing stable and predictable funding sources, recruiting and retaining the extraordinary individuals who staff our nation's safety net hospitals must also continue to be one of our highest priorities if this extraordinary resource is to be preserved in the future.

APPENDIX A

The Safety Net—Selected Articles from the First Three Years of NAPH's Quarterly Publication

SUMMER 1988 VOLUME II, NO. 2

D.C. GENERAL'S PCP UNIT A Catalyst For Change

By Kevin Dennis

The young man was brought into the D.C. General Hospital Emergency Care Center (ECC) around 1:00 AM on a Saturday morning. He looked like most of the 80,000 or more patients treated in the ECC during the past year. But tonight was different. The police officers had found him, just moments earlier, walking down the middle of the street. He had a broken arm but was not in pain; nor did he remember how he injured it.

Within moments, he became aggravated and aggressive. He was violent and, although he had a broken arm, his strength was doubled. DCGH security officers, trained in the latest violence management techniques, and other ECC staff restrained the patient and placed him in the ECC's observation room. Once he had been calmed, he was evaluated by medical and psychiatric staff. Within minutes, expert staff were on hand to evaluate the nature and extent of his drug abuse. Would he be a candidate for the DCGH Unit that specializes in the detoxification of substances like phencyclidine (PCP)? Yes.

The DCGH Detoxification and Early Stage Rehabilitation Unit was recently developed to address one of the city's most pressing needs: drug abuse. Because PCP can be purchased inexpensively and is very accessible, it has become a drug of choice and a serious problem in the District of Columbia. The Drug Abuse Warning Network (DAWN) statistics show that, in 1986, the District had 2,114 reported emergency department episodes involving PCP, the highest in the nation. Los Angeles was second with 1,697 episodes. The two cities combined account for 59 percent of the emergency department PCP cases in the nation.

PCP is commonly called *angel dust, loveboat* or *lovely.* It can be used alone, as a substitute drug or in combination with other drugs such as marijuana and cocaine. It can be purchased or used in three forms: powder, tablets or capsules and liquid. In its liquid form, PCP can be sprayed on cigarettes or marijuana or dipped.

PCP can have both short and long-term effects. Physically, PCP can cause flushing, numbness, rapid heartbeat, nausea, restlessness, loss of coordination and uncontrolled eye movements. Even in small doses, PCP can cause euphoria, depersonalization and delusions.

The user may experience the first direct effects within minutes. The high or negative side effects can last from several hours to several days and lingering signs of abnormal brain function, such as memory lapse and depression, may last even longer. The user may have accidents, amnesia or be oblivious to pain. Further, the user may experience paranoia, psychotic reactions, violent urges or physical collapse.

In 1987, DCGH's PCP Unit treated more than 500 cases of drug abuse on its 20 bed unit; amounting to 4,398 patient days at approximately 8.5 days per stay.

The unit works cooperatively with the city's mental health and judicial services to provide a comprehensive state-of-the-art treatment environment. The 20-bed facility provides nine beds for adolescents and young adults (ages 16 to 22 years old) and eleven beds for adults 23 years old or older. The staff of more than 60 (including medical physicians, psychiatrists, psychologists, social workers, nurses, technicians, nutritionists, laboratory technicians, and administrative support) provides around-the-clock treatment and support for each patient. All clinical staff are educated in those treatment issues involving psychoactive substance abuse disorders. In addition, they have been trained in the most current techniques for violence management to protect the individual, other patients and staff from the occasional violently psychotic manifestations of PCP abuse.

"During the first year, we learned about ourselves as well as the patient and the chemical," said Dr. Frank Boruch, acting chairperson of the department of psychiatry and acting director of the unit. "Staff attempt to understand patients within the disease concept of addiction and, as a result, we have become quite effective in helping those patients who will accept our help."

"Our first goal is to provide safe and effective detoxification. Once we see the patient through this crisis stage, we try to be a catalyst for beneficial change," Dr. Boruch said. The unit provides an environment free of psychoactive drugs (including caffeine and nicotine) to help facilitate that change. "Many residents on the unit are surprised and pleased that they can go for more than one hour, or 24 hours, or seven days without drugs and with an increasing sense of self-esteem and well-being," he said.

Dr. Boruch points out that because of the constant variable nature of drug abuse in the District, there is

need for flexibility in admission criteria. The unit will admit polysubstance, cocaine, or other drug abusers, depending on bed availability. "We cannot deny the issue of polysubstance or other chemical abuse in Washington," Dr. Boruch said.

Although the length of stay is anywhere from 72 hours to 10 days, patients are provided with lots of information and large doses of self-examination.

For now, the unit's team is learning to measure success in small increments. Can they get the patient to stay and participate for the duration of the program? Can they get the patient to participate in some form of after-care (long or short-term treatment, or Narcotics or Alcoholics Anonymous community meetings)? Have they provided some form of intervention in this person's life that may ultimately help?"

We're not changing each of their lives, but we are reaching some and that makes it worthwhile," Finch said.

Kevin Dennis, PCP Unit Administrator, D.C. General Hospital

FALL 1988 VOLUME III, NO. 3

IMPROVING INFANT MORTALITY IN THE HEART OF DIXIE

By Max Michael, MD

Driving south, Sarah felt the contractions getting closer and closer. She had first seen a doctor about five months ago when she began to feel the baby kick. He said to get plenty of rest, eat well, take the vitamins he prescribed for her, and come back in one month. Sarah didn't go back. She didn't have the money for the doctor. And now here she was, having contractions, driving 65 miles an hour on the Interstate trying to find a place to have her baby. She had stopped at two hospitals. One didn't have a baby doctor, and the other said they couldn't help her without a $350 deposit. They told her to go to Birmingham. Sarah was frightened she wouldn't make it to Birmingham, and even if she did, what hospital would she go to?

After driving for three hours, Sarah saw one of those blue road signs with the big "H." She got off the Interstate and followed the signs to the hospital. She was hurting, she was sick at her stomach, her legs were shaking, and she couldn't see the road very well through her tears. But she had made it to Birmingham. At the emergency department the nurse asked her the same questions about a deposit and health insurance. All she could say was "Help me have my baby!" Instead she was told to drive on to University Hospital. Sarah's last stop was University Hospital. They asked the same questions as she was taken directly to the labor and delivery suite. "You're lucky," the doctor said, "your baby is fine." Sarah didn't feel lucky. She was tired and angry. Alabama is a poor state. The average annual per capita income is about $12,000. From the Appalachian foothills to the coastal plains, a few large cities interrupt an otherwise completely rural landscape peppered with small communities that are often very isolated from each other. Birmingham boasts one of the nation's premier medical centers, yet the majority of the state's counties are without obstetrical care. As a result of inadequate prenatal care, the infant mortality rate for Alabama is among the highest in the nation.

Alabama also has the stingiest of Medicaid programs. If a family of three earns more than $1,416 per year, they are not eligible for Medicaid. Without Medicaid thousands of poor and near poor pregnant women do not receive any prenatal care.

Sarah's story and the all too frequent complications of a pregnancy without prenatal care was a daily occurrence until July 1988, when Alabama implemented the SOBRA provisions for pregnancy related services and care for infants in the first year of life for families with an income level up to 100% of the federal poverty level. In addition, the state Medicaid agency program received a waiver to conduct a coordinated program of case-managed maternity care through select providers.

Effective October 1, 1988, the Jefferson County Department of Health (JCDH) signed a contract with the state Medicaid agency as the primary care provider for the three county area of Jefferson (Birmingham), Blount, and Shelby counties. In addition to the local health department clinics, an OB Complications Clinic was established at Cooper Green Hospital, the public hospital for Jefferson County and NAPH's newest member. Delivery services are provided through University Hospital, Cooper Green Hospital, and three other community hospitals.

Cooper Green Hospital is a 311 bed public hospital that serves Jefferson County. The hospital was opened in October, 1972, and is an affiliated institution with the University of Alabama Medical Center. The physicians who staff the hospital have their offices in the facility. House staff from the University complement the services provided by the physician group. The outpatient clinics coordinate care with the clinics of the Health Department in order to improve continuity while encouraging patients to use their neighborhood center for most medical needs.

The eventual success of the Medicaid waiver program rests with a long tradition of prenatal care services in Jefferson County provided through the Jefferson County Health Department, Cooper Green Hospital, and University Hospital. A network of eight neighborhood health clinics serves as an entry point for pregnant women. These women are seen by nurse

practitioners or physicians based on clinical protocols. Information from each clinic visit is entered into a unique computerized prenatal record (OBAR) that is always available at terminals in the other clinics and at Cooper Green and University Hospitals. Regardless of where a pregnant woman may come for prenatal care or when she goes into labor, the complete, standardized record is available.

The Medicaid waiver program builds on this existing system of care. The primary provider, JCDH, provides coordinated outreach and education, risk assessment, assurance that each patient has access to appropriate physician and inpatient services, and a system of follow-up with mothers for postpartum services. Case managers are available in all primary care sites to ensure that each pregnant woman keeps her prenatal appointments and has contact with other appropriate social services programs such as WIC.

The importance of the case manager cannot be overly emphasized. Obstetricians working in the Health Department clinics and at the referral hospitals point out that for a poor pregnant women missing an appointment can lead to preventable fetal demise. Because so many of these women are high risk, frequent clinic visits are necessary to carefully monitor the progression of the pregnancy. When a clinic visit is missed, for example, because of transportation problems, the opportunity to anticipate and prevent fetal wastage may be lost. With the case managers these problems should all disappear.

Although this waiver program has operated for only nine months, demonstrable impacts are evident. The number of maternity visits has increased each month from 7% to 30% compared to the previous year. Unfortunately, the percent of women who receive prenatal care during the first trimester remains at 37%, a far cry from the national average of approximately 84%.

Dr. Carole Samuelson, Health Officer for Jefferson County, believes it is too early to tell what effect the case management system will have. "We are pleased with the efforts of the case managers. It will take a while for the word to get out, so that most of the pregnant women will come into the centers to register for prenatal care. Hopefully, we will see an increase in first trimester visits and a decline in infant mortality by next year." Between October 1988 and March 1989, there were 2,272 deliveries under the waiver program. An additional 1,776 women are currently enrolled.

The Medicaid waiver program for pregnant women has other benefits besides the improved access to care. Many of the women elect to deliver at Cooper Green Hospital, which receives a capitated payment from the Health Department. While these women delivered at Cooper Green previously, their care was generally unsponsored. The added revenue from these deliveries has given an infusion of funds vital to the continued successful operation of the hospital. In addition, the close links between Cooper Green Hospital, University Hospital, and the Jefferson County Department of Health has provided a model for additional improvements in the delivery of health care to the needy in Jefferson County.

1989. The drive south is not so bad this time for Sarah. Even though there isn't a doctor in town who can deliver her baby, the nurse at the clinic has seen her five times. The nurse also helped arrange for a friend to drive her to Birmingham where she will stay for the next several days until the baby is born. That should be in the next two or three days.

This time Sarah looks forward to having her baby.

Max Michael is the Chairman of the Section of Internal Medicine, Cooper Green Hospital in Birmingham, AL.

SUMMER 1988 VOLUME II, NO. 2
CRISIS IN TRAUMA CARE: California's Bold Plan Runs Afoul of Financial Realities
by Joyce Berger

California, the gold state, home of sunshine, surf, and healthy vigorous people also home to stabbings, gunshot wounds, car and motorcycle accidents, near drownings, and burns. This healthy state can also be a very dangerous place to live. Violent injuries are still the number one cause of death up to the age of 44, and accidents are the fourth leading cause of death among people of all ages. More children die of injuries than all types of disease combined.

California has the dubious distinction of being well above the national average in pediatric deaths, drownings, near drownings, asphyxiation, falls among senior citizens, and accidental poisonings.

To help combat this carnage, a statewide trauma system was established in 1983 to provide specialized care during the Gold Hour—the time most critical for the patient's survival. California's trauma system is composed of local emergency service authorities, 55 designated trauma centers, and clinicians who comprise the trauma response team. The trauma centers have specialized equipment, an immediately available operating room and general surgeon, and support staff on hand 24 hours a day. Neurosurgeons and other specialists are on call and available immediately. All of this adds up to a very critical, but also very expensive, program.

Trauma care works. Many lives are being saved. However, the trauma system in California is being forced to the brink of collapse because of financial

pressure. The cost of uninsured trauma cases total over $70 million per year. Hospitals can often no longer afford to participate.

In Los Angeles County, the number of trauma centers has decreased from 23 to 16, with new announcements of intent to close being heard almost weekly. What will be left are the County and University Hospitals, many of which, due to bed, staff, equipment, and sheer money shortage, are not equipped to deal with this huge influx of critical patients.

In California, legislative attempts to bail out the trauma system have been blue penciled or killed in committee. The outlook appears almost as bleak for 1988/89.

Trauma centers can be both clinically and fiscally successful if you are lucky enough to be located in an affluent suburb. However, the reality for many public hospitals, especially those who are left in the system, is that their neighborhoods are poor, are often crime-ridden, and have many people who are uninsured. The current cocaine and crack epidemic has also added an enormous number of patients to the system.

In Alameda County, the fifth largest county in the State, this pattern is being repeated. The trauma system became operative on January 15, 1987 with three hospitals participating. These included the County Hospital, a private hospital, and a regional pediatric center. The County's size was felt to require two adult centers. The system has now been in operation for a year, and the private hospital has just given notice that they will cease trauma center operations as of July 1988. They cited severe financial losses as the cause. This situation would leave the County hospital as the only adult trauma center for a population of 1.2 million.

The pediatric hospital is also voicing their concerns over their fiscal plight. Several issues have arisen here that appear to be a common experience. There are many more uninsured victims than anticipated, payment is often tied up for years in court battles, payment from the State Victim of Crime program and local HMOs is often long delayed, and the costs continue to escalate beyond reimbursement.

The glowing expectations and enthusiasm of the early days of trauma system development have given way to a much harsher reality. As the red ink rises around us, the choices the system has become fewer and fewer. One of these choices appears to be volume. A trauma center, with its high fixed cost for coverage and support staff, simply cannot survive on low volume—even given the best payer mix.

The number of trauma centers will also tend to decrease as many of the private facilities drop out. With no help in sight to pay for care for the uninsured, we can look to see more and more of this happening. A much smaller and more far-flung system will result.

County and university hospitals, who generally have been caring for this population already, stand the best chance of survival. Many have developed some mechanisms for subsidy. There is now appearing at the State Health Department level, a glimpse of recognition of the incredible burden that our hospitals, as safety net providers, carry. If this recognition can be carried into policy and that policy into fiscal intervention, there is hope for the future.

The system is valuable—it works and it truly does save lives. As members of the public hospital sector, we must be committed to doing all we can to advocate and agitate for help.

Trauma is a system worth saving, your life may depend on it.

Joyce Berger is the Director of Highland General Hospital in Oakland, California.

WINTER 1988 VOLUME II, NO. 1

REACHING THE MENTALLY ILL HOMELESS: Bellevue Hospital Center is the Cornerstone of New York City's New Initiative for the Homeless Mentally Ill

By Suzanne Halpin

New York City can accommodate about 10,000 persons in existing shelters for the homeless. While not all homeless persons are mentally ill, a study by the New York State Psychiatric Institute showed that about 25% of the city's shelter population had a history or current manifestation of serious mental disorder, and roughly about 40% exhibit some symptoms of mental disorder. This population creates unique problems for the cities and hospitals that can help them.

Many of the mentally ill homeless never come into the New York City shelter system. Some, their judgment impaired by their illness, reject attempts at assistance. Others are simply unaware of available resources. Mayor Edward I. Koch recently initiated a comprehensive effort to provide needed assistance to the mentally ill homeless of New York City. The program is designed to provide hospitalization and treatment, either voluntary or involuntary, to those in need, and to bring those who do not need hospitalization in contact with other forms of outreach services.

Project HELP. Project HELP was established five years ago to serve the mentally ill homeless of New York City. As part of Mayor Koch's new initiative to address the problems of the homeless mentally ill, Project HELP has been revised to focus directly on moving the high risk patient off the street and into a therapeutically appropriate setting. Project HELP's former responsibility for ongoing monitoring and case management of the homeless mentally ill population has been shifted to outreach teams funded by the City Department of Mental Health, Mental Retardation and Alcoholism Services. As part of the revisions to the old program, Project HELP now services the entire borough of Manhattan. If successful, the program may be extended to other boroughs.

The initial phase of the Mayor's program is to identify and make initial contact with members of the target population. These persons are often referred to Project HELP by police, community members or other outreach programs. To accomplish this engagement phase, a three-member team consisting of a psychiatrist, nurse and social worker literally combs the streets looking for persons who appear to be seriously mentally ill. The team is empowered to evaluate and, if necessary, involuntarily transport mentally ill persons to the emergency department at Bellevue Hospital Center. Bellevue is part of the New York City Health and Hospitals Corporation, New York's municipal hospital system. After talking with an individual who appears to be at risk, the team makes an initial diagnosis. Persons who do not meet the legal and clinical standard for hospitalization are referred to other outreach programs. Those who are judged by the team to meet the standard are transported to Bellevue for evaluation by another psychiatrist and, if appropriate, hospitalization and treatment.

Role of Bellevue: Evaluation, Admission, Treatment. The cornerstone of the new program is Bellevue, the designated receiving hospital for the homeless mentally ill picked up by Project HELP. After a potential patient is transported to the Bellevue Emergency Room, a thorough evaluation by a second psychiatrist is initiated. This provides a second opinion regarding whether the patient meets the legal and clinical criteria for hospitalization, forms an initial diagnosis, and determines the appropriate therapeutic setting for the individual. Bellevue has added staff to its Emergency Room to facilitate timely medical clearance and handle hospital escort and support.

If evaluation indicates that hospitalization is required, the patient will—at least initially—be admitted to a special 28-bed unit at Bellevue. This dedicated psychiatric inpatient unit handles the treatment and unique discharge planning needs of this population. Project HELP patients are admitted to other Bellevue psychiatric units when demand exceeds this new unit's capacity. Patients with pressing medical problems are admitted to medical units in the hospital.

Although many new services will be required, an important aspect of Bellevue's role in the new program is expansion of already existing services. For example, specially trained staff have been added to Bellevue's existing Homeless Liaison Program. Similarly, the existing homeless shelter run by the city's Human Resources Administration and located on the Bellevue campus has been expanded to include a special 30-bed unit, to serve as a last resort discharge option for patients from the designated unit who do not require further hospitalization in the long-term facility but for whom no more appropriate discharge option is available. Staffing of the Bellevue Emergency Room has also been expanded.

Because the law allowing involuntary transport and hospitalization requires difficult psychiatric judgments regarding the mental status of the Project HELP patient, Bellevue must play an important role in facilitating clinical consensus between the project HELP personnel who make the initial determination regarding who should be transported to Bellevue and the Emergency Room personnel who decide whether the patient may lawfully be hospitalized. Bellevue is working with other municipal facilities to develop assessment and admission protocols and compatible operating procedures.

Engagement, evaluation and admission of the mentally ill homeless may sometimes seem like an obstacle course for the caseworker and clinician, but even after successful negotiation of those hurdles, the difficult problem of scarce aftercare resources remains to be surmounted. Bellevue and the Health and Hospitals Corporation are playing crucial roles in identification of post-hospitalization placement options for this population, and in creating the institutional linkages necessary to make the transition between hospital and aftercare as smooth as possible. The Four-Year New York City Facilities Development Plan for Homeless Individuals, prepared in conjunction with New York State authorities, already provides for the development of 4400 alternative residential placements, of which half are targeted for the homeless mentally ill. The Plan is now being revised to expand the placement target to 5900.

Under an agreement between New York City and New York State, some Project HELP patients may have access to hard-to-find beds in community residences or, where required, state psychiatric facilities. Creedmoor Psychiatric Center in Queens has designated 50 beds for Project HELP patients brought in under this program. Several Project HELP patients have already been transferred to this facility for continuing care and treatment.

Community liaison workers are available to assist Project HELP patients and social workers in implementing the discharge plan. These workers will accompany Project HELP patients to potential residential placements and assist with their application for after care support and welfare services.

Caught in the Legal Crossfire. A mentally ill person, no matter how seriously ill, may not be involuntarily hospitalized for therapeutic reasons alone—he must also present a danger to himself or to others. In New York State, in order to be subject to involuntary admission, a patient must have a mental illness which is likely to result in serious physical harm to himself or others. The Project HELP controversy has focused on when a person should be considered to be dangerous.

Taking the lead from Mayor Koch and New York City Corporation Counsel, Project HELP personnel and Bellevue psychiatrists are openly taking a broad reading of the self-endangerment requirement. Case law and recent hearing decisions support this view. Under current case law, a person whose mentally illness impairs his capacity to acquire reasonable food, shelter or medical care, or to understand the need to protect himself from obvious danger, is at sufficient risk of serious physical harm to justify hospitalization. Thus, a person whose mental illness results in dangerous self-neglect meets New York's criteria in part for involuntary hospitalization and treatment.

The Bellevue psychiatrists faced with making these difficult judgments on a daily basis are increasingly faced with an additional task; defending these judgments at administrative hearings or in court. Under the New York law authorizing involuntary hospitalization, any person admitted involuntarily may request a hearing and will be provided with legal counsel. Through the first week in January, 60 persons had been admitted to Bellevue through the new Project HELP program. Thirteen of those admitted had requested retention hearings, and the court upheld the need for hospitalization in every case. However, the legal road has not been as smooth as this summary may indicate. The first person picked up under the new program challenged her hospitalization, with the help of the New York Civil Liberties Union (NYCLU). Local and national news media covered her story and characterized the new program as undergoing some kind of test.

Joyce Brown is a former secretary who had disappeared after a family fight approximately a year before she was picked up by Project HELP. At the lower court hearing, psychiatrists presented sharply conflicting expert testimony. Bellevue psychiatrists presented a diagnosis of Ms. Brown as suffering from schizophrenia, paranoid type. They determined that, due to a lack of insight into her mental illness, Ms. Brown was incapable of caring for herself and should not be allowed to return to the street where her condition would deteriorate. Psychiatrists called to testify by the NYCLU lawyers who represent Ms. Brown represented an entirely different picture. According to those experts, Ms. Brown was coherent and rational, with no evidence of psychotic or delusional behavior; her judgment was characterized as slightly impaired.

In face of such conflicting testimony, the judge relied heavily on his observations of Ms. Brown during the hearing, and found that Ms. Brown did not present an adequate risk to justify involuntary hospitalization.

The Appellate Division disagreed and ordered continued hospitalization for the patient. The majority opinion noted that it was improper for the lower court judge to ignore the expert psychiatric testimony in favor of his own courtroom observations. The Appellate Division found it hardly surprising that Ms. Brown, after a week of proper treatment and hygiene at Bellevue, appeared rational. The real issue, according to the court, is her demeanor and behavior when on the street.

The legal battle is not over for Bellevue Hospital or Ms. Brown. Even after the Appellate Division ruling, New York State law requires that City authorities seek a court order for forced medication on any patient, and Bellevue psychiatrists have determined that medication for Ms. Brown is important to the treatment of her illness. Further, the Appellate Division opinion was issued by a divided court, with three judges in favor of hospitalization and two opposed. Ms. Brown's lawyers have appealed. The Court of Appeal's decision may be issued before this edition of The Safety Net goes to press.

Other Project HELP patients have brought the city to court contesting their retention, and have also been denied release. Regardless of the outcome for these patients, one principle remains unchallenged. No court has retrenched from the broad definition of self-endangered which supports the new program and Project HELP. The city remains authorized to evaluate, hospitalize and treat mentally ill persons whose inability to assist themselves places them in danger.

In conclusion, everyone involved agrees that the current choice between hospital and street creates therapeutic and legal problems that are directly related to the policy of deinstitutionalization practiced for years by New York State. Other options are cited by many as preferable to both hospital and street. But many of the options cited may not be appropriate for Project HELP's patients, and many may require funds that do not exist at present. So, for the foreseeable future, the City of New York, the Health and Hospitals Corporation, Project HELP and Bellevue Hospital

Center will continue to do as much as they can for New York City's homeless mentally ill.

Suzanne Halpin is Senior Assistant Vice President for Public Affairs, New York City Health and Hospitals Corporation.

WINTER 1989 VOLUME III, NO. 1

PARKLAND GERIATRIC PROGRAM DERAILS NURSING HOME SHUTTLE

By Paul Long

J.D. Winn had not seen a doctor in 25 years. Suddenly, he could not urinate, and he needed help. The 77-year-old Winn was suffering from a host of ailments, including renal failure. In another time, another place, he would have ended up in a nursing home. Instead, after being treated by the Geriatric Assessment Team at Parkland Memorial Hospital in Dallas, Winn embarked on a new life, an independent life in his own apartment.

Paula Loftis, Director of the 5-year old Geriatric Assessment Team, has nothing against nursing homes. However, in her opinion, not everyone belongs in one. She also believes hospitals should not be dumping grounds for elderly patients.

In the late 1970s, American society became grayer and the Sunbelt attracted more and more elderly people from the North. With advances in modern medicine, the elderly also started living longer. At Parkland, seriously ill, elderly patients were waiting until the last minute to seek medical care. As a result, they would come to Parkland and stay for a long, long time.

The goal of the Geriatric Assessment Team is to treat older patients' medical problems and keep them at home. The team also keeps tabs on the patients at home through community agencies. Loftis makes sure the team provides "one-stop shopping" for the elderly. Many of her patients are too poor and too sick to travel around town from one specialist to another. "The team sits down with the patients and the family and gives recommendations," Loftis said. "Of all the things we offer, that is most appreciated by the family. We will sit down and talk."

Loftis is a clinical nurse specialist. The team also consists of two registered nurses, three social workers, two part-time internists, and a part-time dietitian. The clinic treats about 50 patients a month.

The team also runs the Geriatric Consultation Clinic at Parkland and the James W. Aston Ambulatory Care Center with faculty members from the University of Texas Southwestern Medical Center. The Aston center is at the medical school. The consultation clinic assesses the elderly who have a variety of medical, functional and social problems. Next year, the team hopes to open a four-bed geriatric rehabilitation unit. It will be used to treat and evaluate older patients with functional limitations.

The geriatric team accepts patients who are 65 and older. The average age is 74. Referrals are accepted from doctors, families and friends.

Most of the Parkland patients live alone and have small incomes, and most of them rely on public transportation.

Loftis is trying to change the thinking of doctors and even some families, whose first instinct is to send a sick older person off to a nursing home. She said the attitude seems to be that a nursing home is the natural place for an older person.

"A nursing home shouldn't be your first line of thinking," she said. "You look at whether a person can be maintained adequately and safely at home."

In addition, nursing homes are expensive. Many times elderly people suffer psychologically in nursing homes, where depression is common. Loftis admits that for some people who can not care for themselves or who have inadequate formal or informal support, a nursing home may be the best place. Approximately 5 percent of elderly Americans live in nursing homes.

J.D. Winn was a typical patient for the Geriatric Assessment Team. In addition to a urinary problem caused by an enlarged prostate, he also had heart disease, bad teeth, cataracts and anemia. In the year before he came to Parkland, he had lost 40 pounds. He could not walk and could not care for himself. His mind was fine; he was alert and could talk. Winn showed up one day in the Parkland emergency department. Loftis said if he had waited much longer, he would have died.

The geriatric team choreographed Winn's care. He had prostate surgery. His teeth were fixed. He received medicines for his other ailments.

"The initial reaction was to send him to a nursing home," Loftis said, "but he wanted to stay home if he could. We supported that."

The team helped arrange for Winn to move to a downstairs apartment and to have meals delivered to his home.

If the team had never met Winn?

"I think he would have gone to the nursing home and died," Loftis said.

Paul Long is Assistant Director of Community Relations for Parkland Memorial Hospital.

WINTER 1989 VOLUME III, NO. 1

LIFE-LINE LEGISLATION FOR PUBLIC HOSPITALS

By Jerry L. Buckingham

Early twenty years ago, one of health care's legendary figures, the late Ray Brown, wrote, "The tax-supported public hospital has a long history of being first in almost everything except the heart of the taxpayer." It was a fact of life twenty years ago, and it is a fact of life today. One of the most perplexing problems facing public hospitals in the late 1980s is their ability (or lack thereof) to replace old, worn-out structures.

Things really have not changed all that much from the days when Brown wrote, "Despite the important and impressive role that tax-supported public hospitals have played and are playing in medical education, medical discovery and medical care, they have come upon impossibly evil times. One can gain some notion of how impossible and evil...by checking any large city newspaper on almost any day. The stories are of overcrowding, understaffing, obsolescent and worn-out facilities...and woefully inadequate financing." Remember, this was published on April 1, 1970.

But now, after years of neglect, California lawmakers have thrown a lifeline to the State's aging public hospitals—the flagships of health care for the poor. Enacted at the urging of the California Association of Public Hospitals, the rescue legislation is Senate Bill 1732, a unique approach to new capital financing programs.

This new law is the first glimmer of light in the series of dark, economic storm fronts so well articulated by Brown that have been whipping around public hospitals. For nearly three decades, America's traditionally underfunded public hospitals have been traversing an ocean of fiscal problems, heightened by diminishing State and Federal support, increased industry competitiveness, taxpayer resistance to additional funding, increased volume of indigent patients, escalating operating costs, and the inability to generate much-needed revenue.

The storm clouds on the health care horizon began to darken in 1965 with the adoption of Medicaid (Medi-Cal in California) and Medicare State and Federal programs which were designed to make private sector medical care available to the poor and the aged. With the expansion of "mainstream" services to the poor, health costs doubled, and government countered by lowering its reimbursement to hospitals and private physicians for care of the poor.

Some private hospitals elected to concentrate their services on those who could afford to meet the increased costs of health care, and as public hospitals began to serve more and more of the poor and the aged (groups which include patients with chronic conditions, multiple diagnoses or difficult socio-medical problems), the financial burden on them increased. This influx of patients clogged public hospitals and caused routine overcrowding. In addition, the 24-hour use of safety net hospitals has greatly accelerated the obsolescence of their equipment and the deterioration of their physical facilities.

The woeful history of inadequate financing of public hospitals continued in California with the 1978 passage of "Proposition 13" by California voters. This tax-restricting initiative severely limited the ability of California counties to levy taxes. As a result, county revenues were cut by as much as 40 percent placing a drain on all public institutions, but particularly upon acute care hospitals.

Many of California's public hospitals have already been swallowed up by the vortex of Federal budget cuts and limitations in State and local revenues set by such "tax revolt" measures. During the past 24 years, these battered economic winds have caused the demise of 28 county hospitals which have either been closed, sold, leased or transferred.

Today, only 37 public hospitals are still afloat in 29 of the State's 49 counties. Many of the remaining public hospitals are about to capsize under the weight of deteriorating physical plants and obsolete equipment.

The Los Angeles County/University of Southern California Medical Center, which serves a daytime metropolitan population of 13 million, is typical of safety net hospitals whose facilities are on the brink of collapse. It is comprised of a four-hospital complex of separate, decades old buildings (50 in all)--the largest of which predates World War II. Constructed in 1933, the main unit, General Hospital, is a 900 licensed bed colossus, built without air conditioning or basic hospital systems such as piped gases. The 55 year old giant structure suffers from failing electrical and plumbing systems which are in continual need of repair.

A recent study conducted by the California Association of Public Hospitals (CAPH) showed that at least $1.75 billion is needed to replace or renovate the State's antiquated acute care public hospitals. Fully two-thirds of the needed dollars are required just to provide a safe environment for patients and staff. Funds needed to correct code violations account for 75 percent of the demand, and 17 percent is required for modernization. Underscoring the public hospitals' dilemma, the CAPH study also revealed that private hospitals devote an average of 11.17 percent of their operating expenses to capital projects. In contrast,

ic hospitals spend only 2.17 percent. Expressed in dollars, the privates spend $100.87 per patient day, while public hospitals expend a mere $18.92.

Is it any wonder that public hospitals in California are in such desperate circumstances?

Senate Bill 1732, an innovative law introduced by State Senator Robert Presley, is a measure which offers partial funding to disproportionate share hospitals for capital projects.

Beginning July 1, 1989, through June 30, 1994, hospitals which provide a majority of care to the poor and the indigent can ask Medi-Cal to pay its fair share of debt service costs for new capital projects. SB 1732 allows public hospitals to capture much needed capital funds through an "add-on" in Medi-Cal reimbursement rates. The allotment would be in the form of a supplementary Medi-Cal payment which continues for the life of the loan. The reimbursement is based on the percentage of debt service which corresponds to the hospital's Medi-Cal inpatient utilization rate (the ratio of total paid Medi-Cal patient days to total patient days). To qualify, projects must either cost a minimum of $5 million or be necessary to correct licensing, certification, or other related regulatory standards.

Until now, the distress signals from public hospitals have been largely ignored. The legislature's enactment of Senate Bill 1732 is a timely response to the public hospital system's weakening S.O.S., and may save the State's system of health care for the poor from drowning altogether. Public sector executives, for their part, must display leadership roles in convincing society that its health care infrastructure is sorely in need of major surgery. To do less will lead to a continuing decline in our physical facilities and ultimately to a deterioration in the quality of patient care we render. In the long run, all of society will suffer.

Jerry L. Buckingham is Executive Director of the LAC/USC Medical Center.

FALL 1990 VOLUME IV, NO. 3

MARICOPA COUNTY HEALTH PLAN: A VIABLE ALTERNATIVE?

By Foster Northrop

Arizona is unique. It is the only state to have not participated in the traditional federal Medicaid program. Instead, in 1981 Arizona formed its own version of a health insurance plan for the poor called the Arizona Health Care Cost Containment System (AHCCCS) that fits into the framework of the Medicaid program.

In the past eight years, The Arizona Health Care Cost Containment System has grown to its present enrollment of 290,000. The Maricopa County Health Plan currently has an enrollment of 41,000, and is the second largest AHCCCS contractor in Maricopa County.

In Arizona, prior to 1981, indigent health care was the responsibility of the counties, who either provided the services directly through their public hospitals and health systems or contracted with the private sector. The passage of a "Proposition 13" type law that limited County spending, coupled with a dramatic increase in health care costs, created a fiscal crisis for Arizona counties in 1980-1981. The legislative response was to propose a Medicaid Demonstration Project to be funded by federal, state, and county governments. The bill which created AHCCCS was passed in a special session of the Arizona Legislature in November 1981.

The AHCCCS program was designed as an alternative to the traditional fee-for-service Medicaid program. The goal of the project was to implement and test a health care delivery system and financing mechanism that was more along the lines of a managed care system. AHCCCS set up prepaid capitated payments from HCFA to the State, and from the State to providers. All Medicaid recipients with a few exceptions were automatically enrolled into prepaid health plans. Rates and participation were to be determined by a competitive bidding process. Cost containment would be achieved through utilization management. Gatekeeper/case management responsibilities were to be performed by the primary care physician. And the most important concept was to focus on patient access and quality care.

There are three groups of people who are eligible for AHCCCS. The first group includes Aid to Families with Dependent Children (AFDC) program beneficiaries, Supplemental Security Income (SSI) program beneficiaries, and pregnant women, infants, and children up to age 7 who live in households with income at or below 133% of the federal poverty level. The second group is the medically needy/medically indigent (MN/MI). The third group includes those enrolled in the Children's Care Program.

The Maricopa County Health Plan. The law which established AHCCCS specifically allowed counties to participate in the AHCCCS program as a provider. However, there were no special considerations given to the counties; they were required to compete with the private health plans for AHCCCS enrollees. In 1982, The Maricopa County Board of Supervisors agreed to participate as a prepaid capitated provider in AHCCCS by establishing the Maricopa County Health Plan (MCHP). Over 80% of the services provided to MCHP patients are provided by the County's

550 bed teaching hospital, Maricopa Medical Center (NAPH member), a network of fourteen primary care centers and the Long Term Care Program that provides case management and medical services to patients in nursing homes. MCHP enters into interdepartmental agreements with the hospital, ambulatory care, and long term care for the provision of medical services to MCHP enrollees. Reimbursement is based on the AHCCCS fee-for-service schedule and payment is in the form of capitation or a fee schedule. The hospital and MCHP jointly negotiate contracts with physician groups for professional medical services, and contracts for services not provided within the County system are developed by MCHP.

Rough Beginnings. AHCCCS enrollees, not used to assigned providers, prior authorization, and other features of managed care, initially became confused on how to use the system. When this occurred, many returned to the familiar County system for care

In the second year of implementation of AHCCCS, MCHP lost its contract for 16,000 MN/MI Medicare patients. Maricopa County proceeded to sue the State citing unfair bidding process, adverse patient care impact, inadequate capacity of contracting plans, and adverse patient selection. The County lost the suit. This resulted in a reduction in force of 325 health services positions, the transferring of 16,000 patients to other plans, the closing of two primary care sites, and an attempt by one of the private AHCCCS plans to talk the Board of Supervisors into selling or leasing the hospital and primary care centers.

In 1984, the private contractor hired by the State to administer the AHCCCS program terminated its contract and sued the State for non-payment of claimed expenses. The State countersued the private contractor for overcharges.

Lessons Learned. There are many elements that must function together to produce a prepaid capitated health care program that is competitive, self-supporting, and in compliance with applicable federal, State, and professional statutes, rules, regulations, and standards. The two key elements are the financial management of the plan and the Utilization Management/Quality Assurance Program.

Financial Management. In the first three years of the AHCCCS program, three plans experienced financial problems. This has caused AHCCCS to closely monitor the financial performance of their contracted health plans. MCHP is required to have an annual outside audit, and AHCCCS audits each plan once a year. This is in addition to the quarterly financial reports that must be submitted.

An enterprise fund was established for MCHP within the county government since the plan's operations are financed and operated in a manner similar to private business enterprises. The intent of the Board of Supervisors is that the costs (both direct and indirect) of providing medical services to the AHCCCS population must be financed or recovered through the rates that are paid to the county by AHCCCS.

Utilization Management/Quality Assurance. Management of patient care is important. The MCHP Medical Director is responsible for the activities of the Medical Management Support group which includes utilization management, patient care coordination, authorization, and quality assurance. Utilization management includes the review of enrollees in outside hospitals; discharge planning for all inpatients, and reporting of utilization internally within the plan and to AHCCCS.

MCHP case manages special populations such as high risk maternity patients, high utilizers, and patients with special problems, utilizing alternatives to hospitalization such as home health care, nursing home care and other special services to meet patient needs.

MCHP is required to submit an annual Quality Assurance plan to AHCCCS on how quality will be monitored in the delivery system. AHCCCS conducts an annual medical audit of contracted health plans to assess the quality of care rendered to AHCCCS patients.

The AHCCCS health plan is individually scored in areas such as adult patient medical records, physical facilities and environment at primary-care-physician (PCP) sites. AHCCCS and the health plans also audit the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program.

Success. SRI International, a research organization, conducted a five year study of AHCCCS. In *Overview*, an AHCCCS publication, the results were summarized under four major categories:

- Cost. Over the program's first five years, the average per capita costs for AHCCCS increased at a rate of 23.1 percent while those for traditional Medicaid increased 37.3 percent.
- Utilization. Hospital utilization under AHCCCS was lower than traditional Medicaid and indicated a significant savings.
- Quality of care. Care for children under AHCCCS was in greater conformance with generally accepted guidelines from the American Association of Pediatrics.

- Access and satisfaction. Even though beneficiaries reported some problems with access to emergency care, access to routine care was better under AHCCCS and absolute satisfaction levels were high.

SRI researchers added that AHCCCS "probably does more than any other state Medicaid program" in the area of quality assurance, and the study supports the "simulation of AHCCCS-type Medicaid innovations in other states." We have succeeded in providing medical services within the revenues received from AHCCCS, and overall have had a positive experience with a very different type of health care delivery system.

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APPENDIX B

Public Hospital Series by Emily Friedman

Public Hospitals: Doing What Everyone Wants Done but Few Others Wish to Do

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AMERICAN PUBLIC HOSPITALS —that is, institutions owned by federal, state, or local governments in the United States—today present a series of contradictions.

Among urban public hospitals are several of the oldest health care institutions on the continent, yet that heritage often earns them little respect. Public hospitals in many cities are filled to capacity and suffering severe financial and clinical problems as a result; but in rural areas, lack of business threatens many government health care institutions.

Residencies in public teaching hospitals are often eagerly sought; yet many physicians who trained in such residencies hesitate to refer their patients to these hospitals. Several public hospitals —Cook County Hospital, Chicago; Bellevue Hospital Center, New York City; Boston City Hospital—are legendary in medical history; but the physical plants of the Boston and Chicago hospitals (among others) are sadly deteriorated.

The demise of the public hospital was widely predicted after the passage of Medicare/Medicaid legislation in 1965. But the anticipated wave of closings never took place, and most of those who called for closure or sale of these hospitals have fallen silent.

Editor's Note: This is the first of a four-part series on public hospitals. The second part will appear in next week's MEDICAL NEWS & PERSPECTIVES section.

The federal government issued a postage stamp in 1986 in honor of public hospitals (originally proposed to note Bellevue's 250th anniversary), but has been reluctant to offer financial support to them. Yet public hospitals survive. Some 1600 general hospitals are owned by cities, counties, city-county arrangements, hospital districts and authorities, or states; as many as 300 others also exist. Public facilities represent more than half of all rural hospitals, a large minority of urban hospitals, and the majority of university teaching hospitals.

Philadelphia General Hospital, founded in 1731, was the nation's oldest municipal hospital. It closed in 1977. Next week: Its story in detail.

American Medical News

They are, in some ways, an anachronism—a public force in a private health care market, a huge government presence in a free-enterprise economy. Yet it is probably true of most of them that if they did not exist, they would have to be invented; for they do a job—several jobs, in fact—that everyone wants done, but no one else wishes to do.

'. . . the infirm, the aged . . . '

The public hospital tradition is intertwined with that of the almshouse—the British practice, imported to North America, of establishing a specific institution for those who were viewed as the failures of society. As public hospital historian Harry Dowling, MD, notes, after Henry VIII closed many religious institutions in England in the 1530s, "Local officials found themselves responsible for the aged, chronically ill, and permanently disabled; homeless women before and during childbirth; foundlings and orphans; the insane, feebled-minded, and alcoholics; and persons with medical and surgical illnesses who today would be placed in a general hospital" (Dowling HF: *City Hospitals*. Cambridge, Mass, Harvard University Press, 1982).

At a time when "respectable" people received care at home, those who could not were social outcasts, even if their only crimes were illness and poverty. The almshouse was also a workhouse, where able-bodied pauper and recovering patient alike were expected to work off at least part of what they owed society for shelter, food, and what medical care had been afforded them.

That tradition, too, followed the emigrants to colonial America. Almshouses were founded early on—in Henricopolis, Va, in 1612; in New Amsterdam (New York) in 1658; and in Boston in 1665, for example.

But these early institutions would not become hospitals. They did care for the sick; but this task was not viewed differently from any other in the almshouse. Nor were the ill differentiated at first from healthy paupers or other "undeserving" residents. It was in these early days that one attitude took root that continues to haunt public hospitals: the idea that because the inmates (as they were often called) were not socially worthy, the conditions in which they were given food, shelter, and medical care need not be equal to conditions elsewhere.

Indeed, in puritan America, it was appropriate that almshouse conditions be less than kind, so as to encourage the inmates to reform and go back into productive lives in society as soon as possible. This attitude extended, illogically, to the aged, infirm, and chronically ill who constituted a significant part of the almshouse population. Why one came to the almshouse was, in fact, much less important than the fact that one did.

As a result, writes University of Pennsylvania historian Charles Rosenberg, PhD: "Admission to an almshouse ward—even for unavoidable illness or injury—was a confession of failure" (Rosenberg C. From Almshouse to Hospital: The Shaping of Philadelphia General Hospital. *Milbank Fund Mem Q* 1982;60[1]:108-154).

The first almshouse that would evolve into a public hospital was founded in Philadelphia in 1731 or 1732. It provided medical care for inmates who were already there, and also admitted patients whose sole reason for seeking refuge there was illness. On Jan 21, 1736, a French seaman and merchant named Jean Louis died in his adopted city, New Orleans; he willed his estate to establishment of a hospital there for the poor, which was done on March 10 of that year. This institution would become Charity Hospital.

Later in 1736, the Bellevue Infirmary was founded "on top of the first almshouse in New York, located at the present site of City Hall," reports Marty Davis, spokesman for the New York City Health and Hospitals Corporation. Its charge: to house "the infirm, the aged, the unruly, and the maniac."

The founding of Charity and Bellevue at almost precisely the same time has led to a lively debate between the two as to which is the oldest continuously operating hospital in the United States. (Philadelphia General closed in 1977.) Bellevue's claim is based on the fact that New York became a state in 1776, whereas Louisiana did not become one until 1812. Charity's advocates point out that as neither New York nor Louisiana was a state at the time the hospitals were founded, the determining factor should be the age of the institution.

Bellevue has temporarily won the battle, having been selected as the site for the introduction of the "Public Hospitals" 22-cent stamp in 1986. It must be added, however, that the stamp had been the brainchild of the late Sen Jacob Javits of New York, and the ceremony might well have been held at Bellevue in any case.

Other almshouse-hospitals followed: in Baltimore in 1776, Washington, DC, in 1806, Cleveland in 1837, Seattle in 1877, Los Angeles in 1878. Boston City Hospital was founded as a freestanding institution in 1864, as was Cook County Hospital in 1866 in Chicago. Smaller communities were also erecting almshouses.

David Rothman, PhD, director of the Center for the Study of Society and Medicine at the Columbia University College of Physicians and Surgeons, notes that "between 1820 and 1840, some 60 towns in Massachusetts constructed new almshouses, and many others rehabilitated existing ones. By 1840, the state had 180 almshouses." In New York, he says, "By 1833, all but four of the state's 55 counties had erected a poorhouse." The same was true in many states.

Rothman adds: "The essential function of the almshouse, until the 1830s, was to serve as the great catch-all: it housed those who were unattached to family or other social support and who had no call on private charity. The 'worthy poor' were connected—to family, friends, or church. The 'unworthy poor' were unconnected."

As a result, these institutions had a highly heterogeneous population to deal with—able-bodied paupers (although these were probably few in number and became even more scarce as time went on), unwed pregnant women, the frail elderly, unwanted or disabled orphans, alcoholics, victims of contagious disease, the severely mentally ill. As the 19th century proceeded, another group appeared: immigrants, especially ethnic minorities, who were also "unconnected."

After Massachusetts General Hospital was founded in 1821, for example, its services were soon sought by large numbers of immigrants (Boston City Hospital would not be founded for another 43 years). Dowling notes the resistance of the hospital's board of trustees to caring for Irish patients, because, the board claimed: "Admission of such patients creates in the minds of our citizens a prejudice against the Hospital, making them unwilling to enter it. It thus tends directly to lower the general standing and character of its inmates" (Dowling, *City Hospitals*).

In time, Boston City Hospital would provide a solution to such problems, although Massachusetts General dropped its restrictions on certain ethnic groups before the city hospital was built. In general, long after the private hospital appeared, the almshouse-hospital was still expected to care for the unworthy or unconnected patient.

Rosenberg points out that until World

Hennepin County Medical Center Photo Archives, 1905

The staff of Minneapolis City Hospital and some of their patients in 1905.

War I, "the proportion of men to women in urban public hospitals was as high as two or three to one. The reason is that these patients were unconnected workers—a large proportion of them immigrants. Also, it was a much bigger disgrace for a woman to be a patient in a public hospital than for a man to be there."

Later—and it remains the case—black and other nonwhite Americans would also be cared for, to a disproportionate degree, in public hospitals.

Emergence From the Almshouse

Gradually, the public hospital began to emerge from the overall context of the almshouse. Several factors contributed to the change, of which two were paramount.

First, social reformers started to separate out the various populations that had been grouped in the institution. Rothman says, "What sparked this was the coming of a persuasion in the early 19th century that if the perfect institutional routine could be devised, it would solve the problem at hand." Thus more specialized institutional environments were needed. He adds, "The idea was that a well-ordered, well-disciplined prison or mental hospital instills in the patient habits of order, thus effecting a cure."

As a result, he says, "Children went to 'orphan asylums.' The mentally ill went to mental asylums. Petty criminals often ended up in jails."

Furthermore, he says, "Some of this cult of asylum did spill over onto the almshouse; there was some notion that the almshouse could rehabilitate its inmates. But the almshouse never became an honored institution in pre–Civil War America, the way that prisons and mental hospitals did. They became the glory of the new republic; de Tocqueville came to America, in fact, to study our prisons."

The almshouse did not join the institutional honor roll; but as the people housed there for social reasons were drawn off, the medical and quasimedical populations remained. In some cases, these people had already been separated out from the others, by means of differently colored uniforms, distinct wards, and, more and more, separate infirmaries whose sole purpose was to provide medical care, whether acute, long-term, or psychiatric.

A second factor leading to the development of the public hospital as an entity in itself was another deeply rooted almshouse tradition: medical education. Patients avoided the almshouse unless they were in extremis; but physicians eager to teach and learn were drawn to it.

The history of medicine was written in part within the forbidding walls of Philadelphia General Hospital, where Benjamin Rush and later Samuel D. Gross taught; of Cook County Hospital, where Christian Fenger became a legend; of Boston City Hospital, where David Williams Cheever was a member of the original attending staff; and many other public institutions. This legacy of excellence has continued, in some hospitals. Ronald Anderson, MD, director of Parkland Memorial Hospital, Dallas, points with pride to the fact that two

Nobel laureates see patients at Parkland. Bellevue physicians Andre Cournand, MD, and Dickinson Richards, MD, garnered the Nobel Prize for medicine in 1956 for their contributions to the development of cardiac catheterization. More recently, Olga Jonasson, MD, a surgeon at Cook County (also professor of surgery, University of Illinois, Chicago), headed the national Task Force on Organ Transplantation.

Given that they were the only places where physicians and students had access to patients who could be required to participate in teaching (and where was born the unfortunate phrase, "clinical material," to describe them), it is not surprising that medical education came early to the almshouses. The most stigmatized of institutions became the teaching grounds of the most prestigious of physicians.

However, medical education in public hospitals prior to the 20th century was mostly a passive experience for the students. Large clinics held in amphitheaters consisted of lectures and demonstrations by faculty members who only rarely allowed a student to enter the pit and actually examine the patient.

Sometimes there were "ward walks" as well, in which an attending physician and students would tour patient areas. One story, apocryphal or not, tells of a patient at Cook County in the late 1800s who observed such a group walking through and then turned to a fellow patient to say, "Ole, we ought to be a hell of a lot better. The professor has just walked by."

Nevertheless, as the years wore on, more and more students attended lectures and demonstrations and watched autopsies and physical examinations as part of an increasingly formal education process. Residents became a fixture at the teaching hospitals and would remain so for more than a century; in many hospitals, they became the unquestioned rulers. A tension that still exists today became apparent: "House officers tended to believe that administrators were not really interested in making people well, but only in getting involved in politics, pinching pennies, and slavishly following a rigid set of rules. Administrators, on the other hand, felt that house officers, in their zeal to learn and practice, were willing to flout every rule to the point of destroying the hospital" (Dowling, *City Hospitals*).

For both social and technical reasons, physicians had an incentive to improve and refine the public hospital and separate it from the almshouse by the mid-19th century. Attending physicians and residents alike played a key role in upgrading what were often appalling conditions—poor food (some patients developed scurvy during their stays), inadequate nursing (which, until Florence Nightingale's ideas were promulgated widely, was often provided by other inmates), understaffing, unproductive political appointees in key jobs, insufficient plants and equipment. Physicians, often in partnership with crusading "society ladies," helped ameliorate some of the worst problems.

Rise of Private Hospitals

After the Civil War, the revolution in medicine changed the status of the hospital—no matter what its ownership—from the site of care of last resort to the best place to receive care. Private hospitals started to come into being at the same time that public hospitals were achieving identities separate from the almshouses.

Why did the public hospitals survive? Why were they not abandoned in favor of private facilities?

There were many reasons: a public hospital infrastructure in many cities; the social and clinical unattractiveness of many public hospital patients; the fact that private patients would be less willing to participate in teaching activities (given that they usually had a choice, unlike public hospital patients); and the desire of governments to retain the power, prestige, and patronage that accompanied public hospitals.

The increasing effectiveness of medicine was also a factor. If society accepted the idea of segregating the undeserving and/or unconnected poor, it still had to grapple with the question of whether they should be denied the benefits of health care. (This was an interesting ethical question, given that it was largely the almshouse poor whose bodies had been used to learn much of what was making medicine more effective.)

As Rothman says, the public hospital provided a perfect solution: "The municipal hospital performed the function of keeping everyone's conscience clear in terms of health care for the lower classes. Once hospital care was understood to be socially desirable, and, indeed, very important, could society really say that those without funds should go without it? The answer was, 'No. We have a municipal hospital as our grand act of charity.'"

Most of the context of the contemporary urban public hospital, then, had been established by the late 19th century. The nature of the teaching relationship changed, of course, especially after the release of the Flexner Report in 1910 and the coming of stricter standards for medical education and medical care itself.

The growth of private university hospitals, and private hospitals affiliated with medical schools, created a competition for resources and faculty in which many public hospitals came out second best. But many did not; and the ever-present residents continued to serve as a force for high quality of medical care, if they were not always as effective in achieving high-quality overall conditions in the hospitals.

The final element influencing the development of the public hospital has been its public ownership. Government in the United States has a curious love-hate relationship with itself, which is reflected in the ambivalence it shows toward the institutions for which it has responsibility. Nowhere is this more evident than in the public hospital. This is not to say that politicians have ignored public hospitals; indeed, figures such as Mayor James Michael Curley of Boston and Gov Huey Long of Louisiana were vocal proponents of the institutions they sponsored.

But they and others tolerated corruption, patronage hiring, underfunding, lax accounting and management practices, and the erection of cumbersome, sometimes impossible procedures that made the operation of the institutions a nightmare. In many cases, these practices were not only tolerated, but encouraged. This hobble was in evidence soon after the first public hospitals were built, and its scars are deep in many cities.

Politicians, for obvious reasons, also liked to build huge institutions. In 1910, Cook County Hospital had 1350 beds; by 1960, it had 3260. In 1910, Boston City Hospital had 1061 beds; by 1950, it had 2376. Similar figures could be cited for other cities. Given the hospital administration axiom that no facility larger than 500 beds is manageable, these behemoths would have been a problem even if they had not often been labyrinthine mazes constructed in stages on the bones of 18th- and 19th-century plants.

Nevertheless, the end of World War II saw the public general hospital still very much in evidence. It was often a prestigious teaching facility if located in a city—and most of the 100 largest cities had at least one such institution. The passage in 1946 of the so-called Hill-Burton legislation, which made federal

funds available for hospital construction, spurred rural areas to build hospitals, the majority of them publicly owned—often by hospital districts, which became popular in the late 1940s, especially in the West.

Not only did public hospitals survive in the postwar period; they multiplied. In 1946, there were 785 general short-term hospitals owned by states and localities; in 1955, there were 1120. By 1960, there were 1260; by 1965, 1453.

Decline of Sanitariums

At the same time, one class of public hospitals was headed in the other direction. Of all the contagious scourges that had swept the populace in the 18th and 19th centuries, tuberculosis had proved one of the most intractable, and public sanitariums had become a fixture in most states. Changes in treatment had a fatal effect on these institutions from World War II on: in 1946, there were 412 nonfederal tuberculosis and respiratory disease hospitals; in 1955, there were 347. From then on, their doom was speedy: in 1960, there were 238; in 1965, 178; in 1970, 101; in 1975, 36; in 1980, 11; and in 1985, 7.

A staple of 19th-century society has passed from the scene. An event that many predicted would cause most public hospitals, at least in the cities, to suffer a similar fate took place in July 1965: Congress passed Public Law 89-97, creating Medicaid and Medicare.

Time had dimmed the remembrance of the heterogeneous constituency of the public hospital; it had been forgotten that although most of the patients shared the state of poverty, it was about all they did share. The chronically ill, the person suffering from both medical and psychiatric problems, the homeless, the alcoholic, and those compromised in other ways were all still largely the responsibility of the public hospital. But in the flush 1960s, they were all grouped together as simply the poor and sick. And Medicaid and Medicare were configured to underwrite the care of the majority of the poor and the sick at any hospital, public or not (even if in the long run, that did not prove to be the case).

It was widely predicted that, given a choice, the public hospital patient would abandon that institution for more comfortable private hospital care. Many of them did. Medicare patients, particularly, fanned out among many institutions. Many patients in need of long-term care found a welcome in the burgeoning nursing home and intermediate care facility industries. And many of the poor tested private waters as well.

Most urban public hospitals faced a decline in inpatient utilization, and they reacted by reducing the number of beds they operated. Boston City Hospital's 2376 beds in 1950 had dropped to 859 by 1970; Cook County Hospital's 3260 beds in 1950 were down to 2263 in 1970. District of Columbia General Hospital lost 433 beds between 1950 and 1970; Baltimore City Hospitals went from 1810 beds to 857 in the same period. Los Angeles County Hospital (later Los Angeles County–University of Southern California Medical Center) had 3439 beds in 1950 and 2105 beds in 1970; San Francisco General Hospital went from 1101 beds in 1950 to 822 in 1970.

Alan Sager, PhD, an associate professor at the Boston University School of Public Health, reports that between 1950 and 1980, the number of urban public hospital beds declined by 38.3%, while private urban hospital beds increased by 60.6%. Some entire institutions closed as well. But no massive rush of closings materialized.

Why not? There is no one answer. But one major factor was that, as Rothman says, "Voluntary hospitals remain uncomfortable with large numbers of any down-and-out group, whether or not they are insured: the Skid Row alcoholic, the Skid Row AIDS patient, many other marginal patients. It is not at all clear that the public hospital's mission of serving the undesirable was necessarily obviated by Medicare and Medicaid."

Furthermore, although Medicaid and Medicare started out paying hospitals fairly well, Medicaid payments soon declined, in some states precipitously. Furthermore, Medicaid never covered the entire poverty population. At its height in 1977, it sponsored 92% of those living below the federal poverty line, according to the Health Care Financing Administration; other analysts argue that it never came that close. Today, Medicaid covers between 38% and 42% of the poverty population.

Finally, the role of the urban public hospital (whether university-owned or university-affiliated) in medical education remained central, some 200 years after Benjamin Rush first made rounds at the Philadelphia almshouse. In 1976, a national commission on public-general hospitals was convened by the Hospital Research and Educational Trust, an affiliate of the American Hospital Association. With support from the Robert Wood Johnson and W. K. Kellogg foundations, it conducted an in-depth study of government hospitals. It reported on its findings in 1978.

Among the highlights of the report: in 1976, more than ten years after the enactment of Medicaid and Medicare, there were 1905 public general hospitals in the United States. In addition to those located in the 100 largest cities; 357 were located in other metropolitan areas; 45 were university-owned; and 1413 were rural. Of the 100 largest cities, 76 still had public facilities: 49 had one, 21 had two, five had three or four, and New York City had 15.

Perhaps most striking, the occupancy rates in these hospitals were far higher than might have been expected: 69.9% in all public facilities, 76.5% in university facilities, 73.7% in urban facilities in the 100 largest cities, 72.4% for other metropolitan facilities, and 65% in rural facilities.

The same year, average occupancy for all US hospitals was 76%; for private nonprofit acute general and related hospitals, it was 77.1%; for investor-owned acute facilities, it was 64.8%. In 1978, public hospitals in the aggregate accounted for 45.3% of all ambulatory hospital visits in the country, and nearly half of such visits in the 100 largest cities. They trained nearly 40% of all medical and dental residents and 20% of other health care professionals who trained in hospitals. Public facilities represented 48.5% (1413) of the 2912 rural hospitals in the United States, and 67% (99 048) of the 147 387 rural hospital beds. Reports of the death of the public hospital had been greatly exaggerated. It had not triumphed, perhaps, and there had been casualties, but it had survived.

In 1732, the Philadelphia almshouse opened its ambivalent doors to the homeless outcasts of a judgmental society. Four years later, the almshouse that would become Bellevue did the same. In 1864, Boston City Hospital was completed. It seemed somehow fitting, then, that as urban homelessness made a tragic comeback in the 1980s, some of these landmark institutions would come full circle.

In the early 1980s, Boston City Hospital opened a shelter for the homeless in a public long-term care facility. Bellevue Hospital Center moved into a modern tower in 1975, but many of the buildings on its campus had by then earned historic landmark status. Recently some of those buildings were reopened, also as shelters for homeless people. These new outcasts now sleep amidst the ghosts of brethren who have sought similar refuge within those walls for 250 years.—by Emily Friedman

Demise of Philadelphia General an Instructive Case; Other Cities Treat Public Hospital Ills Differently

DESPITE THE REMARKABLE staying power of public hospitals, not all have survived. The pattern of closure, however, is complex, especially in cities. Alan Sager, PhD, associate professor, Boston University, conducted a survey of hospital closings in 52 large US cities between 1937 and 1980. Defining a closure as "cessation of acute inpatient services in a hospital within the city boundaries," he found "only three public hospital closures or relocations outside the city between 1937 and 1950." From 1950 to 1959, there were six; from 1960 to 1969, there were three. From 1970 to 1980, however, there were ten.

Editor's Note: This is the second of a four-part series on public hospitals. The third part will be in next week's MEDICAL NEWS & PERSPECTIVES section.

"There was a burst of closings between 1978 and 1982, probably due to recession and economic problems," Sager reports; four more hospitals were shuttered between 1980 and 1983 for a total of 14 in the five-year period. However, there have been no closings among the hospitals in his sample since 1983. Sager ascribes this apparent deceleration to "a perception that the need for public hospital care has grown with the increasing number of uninsured patients," of whom the current Census Bureau estimate is 37 million or more. Also, he says, "I think local government has become more sophisticated, and when it desires to contain its obligation to the uninsured, it finds methods more politically palatable than closure."

Elliott C. Roberts, chief executive officer of Charity Hospital in New Orleans, has overseen public hospitals in New York City, Detroit, and Chicago, as well as in New Orleans, and he resists generalizing about closures: "Each situation is unique."

Dennis Andrulis, PhD, director of research and policy of the National Association of Public Hospitals (NAPH), adds, "It is difficult to say if there has been a trend in the closing, sale, or lease of urban public hospitals. It's an idiosyncratic process, dependent on a number of political factors. A politician might use his or her own clout to put forth a proposal that would adversely affect a public hospital; but that doesn't happen too often. What does happen is that from time to time, a critical point is reached in terms of the capital cycle of a facility. There may be periodic attempts or proposals to change the ownership of a public hospital, but it happens most when there is need for either renovation or replacement."

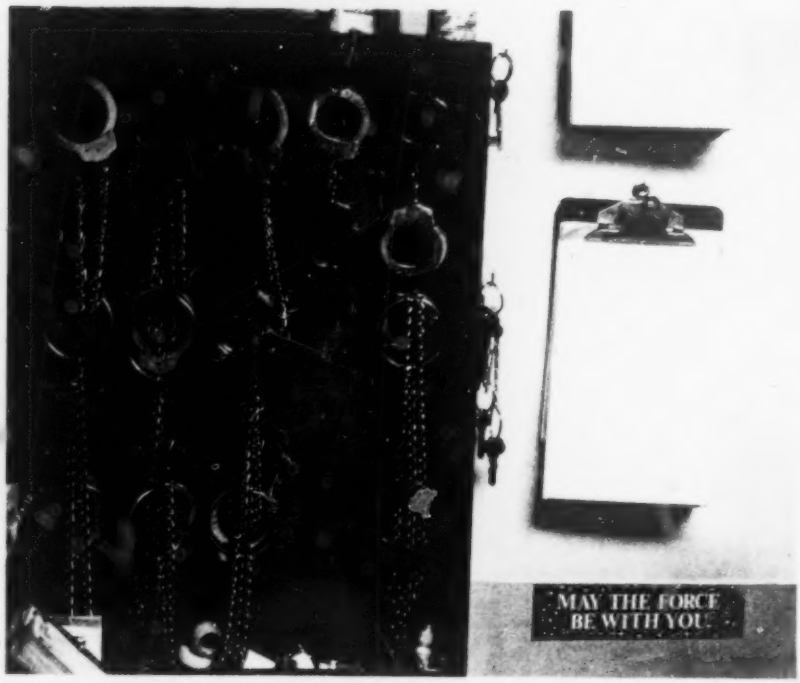
The Philadelphia Story

Of all public hospital closings in the past 20 years—if not of all those in the modern era—none has been studied, discussed, or debated as much as the 1977 closure and subsequent demolition of the oldest hospital of any kind in the United States, Philadelphia General Hospital (PGH). Its closing appears to be more controversial in hindsight than it was at the time; as Charles Rosenberg, PhD, a historian at the University of Pennsylvania, has observed, "It succumbed with surprisingly little public protest" (Rosenberg, *From Almshouse to Hospital*).

The core issue, in fact, was not whether the hospital should have been closed; by 1976, when the decision to close it was announced, PGH was a largely empty, deteriorating hulk. Ernest Zeger, executive director of the public Philadelphia Nursing Home, who served as general director of PGH during the closing process, recalls, "In 1976, there were as many as 1800 beds that were not being used on any given day. Its facilities were antiquated, and with Medicaid and Medicare, the patients were not coming to the hospital for acute care. We were down to around 250 acute patients, and 400 'disposition patients'—those who did not need acute care but placement of whom in other settings was not possible."

Philadelphia General Hospital still had approximately 160 000 outpatient visits a year, however. The question is how, in 30 years, one of the most prestigious teaching hospitals in the country, where obtaining a residency was a major accomplishment, could fall on such hard times.

For long-time observers of the Philadelphia scene, there is little mystery about it. "Prior to the end of World War II," says Robert M. Sigmond, scholar in residence at Temple University and former president of Philadelphia's Albert Einstein Medical Center, "PGH was an extremely fine medical institution. Physicians seeking to become specialists by an informal process were delighted to be associated with it. When residency requirements changed, spe-



Emily Friedman

Wall of the sheriff's station at Denver General Hospital in Colorado

cialty boards sought full-time directors of programs, however, and residency programs began to shift. The public hospital model was no longer seen as the preferred model. So good liberal thinking began to favor affiliation of public hospitals with medical schools."

Enter Philadelphia politics, particularly the 1951 city election, in which power was seized from the old Republican machine by a reform-minded, if elitist, Democratic administration headed by new mayor Richardson Dilworth. Walter Lear, MD, president of the Institute of Social Medicine and Community Health, who served as acting executive director of PGH in 1967-68, recalls, "The basic philosophy of the new administration was couched in terms of 'public-private partnership,' as we now use the term. It was expressed in a variety of major city activities. The administration assumed that the city's medical schools, of which there were five (University of Pennsylvania, Temple, Thomas Jefferson, Hahnemann, and what was then Women's Medical College), had the talent and credibility to take over leadership of the city health department," which included PGH and an infectious disease hospital that was closed in the 1950s.

In 1958, the Dilworth administration pushed through an affiliation plan that involved all five medical schools in the operation of PGH. The goal, according to health policy analyst Paul Socolar, was "a reorganized PGH under private, expert management, freed from the patronage system" (Socolar P: The closing of Philadelphia General Hospital. Presented at the 1986 Meeting of the American Public Health Association.) What the city got was something less.

"No one was really responsible for programs at PGH," Sigmond recalls. "Each medical school had its own special interest. In medicine, for example, there were five services—each an adjunct of the overall service at the medical schools and the hospitals they owned. No one was focusing on the institution as a whole." Lear adds, "The medical schools were primarily interested in their goals, which were good teaching programs; as long as they could count on a quantity of medical service activity to meet the requirements of residency training, they were satisfied. They didn't really care what was happening to the hospital otherwise. I don't mean to depict the medical schools as consciously and deliberately trying to kill PGH; they just did not have any real interest in its survival. They pursued those activities that they considered appropriate to meet their goals as academic medical institutions."

Interinstitutional rivalries and tensions led to problems in division of responsibility, and later to virtual warfare. Eventually all the schools but the University of Pennsylvania either withdrew from the arrangement or were forced out. At the very end, Hahnemann was the only medical school involved, and then only briefly, according to Lear.

The lack of medical school loyalty to PGH as an entity might have been balanced by the city, but the municipal government "was less than vigilant," according to Socolar. Dilworth was succeeded by James Tate, who was more of a practitioner of patronage politics. As PGH was no longer available for patronage jobs because of the medical school affiliations, the city did not focus on the hospital or its problems. In fact, in 1969, after the passage of Medicaid and Medicare and a concomitant loss of some patient volume, Tate offered "to turn the hospital over to the University of Pennsylvania altogether," Socolar reports, but the offer was rejected.

Other nails were driven into PGH's coffin during the 1960s. Sigmond reports that although federal health dollars were available almost for the asking for urban health initiatives, "PGH, to the best of my recollection, did not respond at all." As a result, he says, "The energies that were mobilized in Philadelphia in terms of community health and leadership among the poor went in other directions. There were no Great Society initiatives at PGH, although there were at other hospitals—Einstein, University, Hahnemann, and Temple."

So patients eligible for care under those initiatives were drawn away from PGH. Meanwhile, the hospital's 1920s physical plant was beginning to fall apart. Finally, changes in medical education during the 1960s brought an end to PGH's long-time irreplaceable role as the center of teaching in the city. Private hospitals were now heavily involved in teaching activities, and privately insured patients as well as the indigent were the focus of educational activities. Also, with more payment available, low-income patients were being treated at many hospitals, including those owned by the medical schools.

By the late 1960s, only the University of Pennsylvania still conducted extensive teaching activities at PGH. Socolar and other critics charge that the university took advantage of the situation; its own hospital being within a stone's throw of PGH made it easy to "skim" paying patients and refer them to the university hospital, he says. Certain

teaching programs were transferred to the private facility in their entirety, including pediatrics, obstetrics, and neurosurgery.

Although the accusations against the medical school may well be overdrawn, there are indications that it was not overly concerned about the ongoing decline of PGH. That may not have been its responsibility; the hospital, after all, was owned and subsidized by the city, and the primary guardian of the hospital should have been the city. As Sigmond observes, "The medical school wasn't the villain; there was no massive plot. It was just a case of clinical department heads acting like typical clinical department heads of that era. The problem was really the failure of the city to create a mechanism to protect the mission of the institution."

In 1971, a master plan to build a new 600-bed acute care facility was announced, and $945 000 in planning funds was approved in the November election that year. But that election also saw former police commissioner Frank Rizzo chosen as mayor, and that spelled the end of PGH. Rizzo said as early as December 1971 that PGH should be closed, Lear reports, and that was that.

Although the formal closing was announced in 1976 and completed in 1977, PGH's last years were spent in a dismal environment of declining patient volume, disinterest on the part of the city and most of the medical community, and continued deterioration of the physical plant. Rizzo attributed the decision to close PGH to its crumbling physical plant and the unavailability of capital to rebuild it. However, the real reason was rooted in decisions made by an administration 20 years gone. As Rosenberg observes, "The city's saying that PGH had to be closed because it was a poor-quality hospital was equivalent to pleading for mercy as an orphan after you've killed your parents."

The actual closing was more controversial on technical grounds than on philosophical ones. Mark Levitan, now president of Albert Einstein Medical Center, was executive director of the Hospital of the University of Pennsylvania from 1974 to 1983, and he recalls fearing that his hospital "would be inundated with patients." Once PGH was gone, he says, "The only effect was in obstetrics, where our caseload increased by 500 or 600 deliveries. Otherwise there was no evidence that our hospital or, to my knowledge, any other hospital saw much of an impact." Levitan recalls, "What we took issue with was not the closing, but the process."

Zeger contests this view, pointing out that the city established six outpatient family care centers, each affiliated with a backup hospital, and operated outpatient services at PGH for a year to ensure that patients would be enrolled in one of these centers. "I think the program worked very well," he says.

The city also converted a former state tuberculosis hospital into the Philadelphia Nursing Home in order to provide care for the 400 or so chronically ill and otherwise hard-to-place "disposition patients" who were left at PGH at the end. One woman patient was described at the time as having lived in the hospital for decades. The nursing home continues to provide services, operating at 90% occupancy, soon to be 95 to 98%, Zeger reports.

Nevertheless, there seems to have been widespread confusion about the closing, chiefly because there seems to have been widespread ignorance about how many patients the hospital was treating, who they were, where they would go—and what patients were supposed to do once PGH closed. Although there was an information campaign, its design was curious for a program seeking to inform low-income, socially marginal individuals. For example, one technique used—placing ads in the *Philadelphia Inquirer*—was likely not the best way to go about it.

Questions Remain

Two questions remain, after all these years. One is, why was there relatively little opposition to the closing? In other cities, there have been demonstrations, sit-ins, and near-riots when public hospitals were closed or threatened with closing. But not in Philadelphia. For one thing, says Sigmond, "Historically, PGH's constituency was more a medical-political one than a social one. I don't think low-income people were ever well-organized in this town, politically or otherwise."

Lear adds that the hospital's civil service physicians, "the principal advocates of PGH," had largely been deprived of power and voice over the years. As for the union representing hospital employees, he says, its leaders were convinced early on that the hospital would be closed, no matter what, and thus "devoted their energies to fighting for other jobs for their members, rather than fighting for the survival of the hospital." At the end, according to Lear, PGH "did not have a really loyal constituency that had any power."

The other question is, what was the effect of the closing? This is the focus of continued debate, even today, simply because there are no data. The Fellowship Commission of Philadelphia conducted a three-year study that was released in 1979 and concluded that "services were generally 'available' for most former users," although it could not account for "the fact that aggregate use rates at other facilities failed to increase enough to compensate for the absence of the public services" (Isaacs M, et al: *The Urban Public Hospital: Options for the 1980s.* Washington, DC, Alpha Center, 1982.) However, there have been so many changes in urban hospital utilization that this does not necessarily mean compromised access to inpatient care. Also, the acute care census at PGH was quite low at the time of the closing; it would be difficult to track absorption of a few hundred patients in a city with so many hospitals.

On the other hand, Lear quotes from a press release issued in connection with the commission report: "Tens of thousands of financially needy and/or medically underserved Philadelphians did not have their health care needs met by the combined health services of public and private facilities before the closing of PGH, and their needs are still not being met today." No study has tracked individual patients; the Fellowship Commission sought to examine medical records, but the request was refused on grounds of confidentiality, according to Lear. Although the debate will continue, as the years pass, it becomes less and less likely that anyone will know whether access to acute inpatient care was affected by the closing.

Access to other forms of care is another matter, according to Zeger, who cites possible problems for patients with "combinations of medical problems and mental disability, for whom there is no longer a viable institution." These patients, he says, fall into a crack between the hospital and the nursing home. He also expresses concern about the homeless, because there is no "institution of last resort" for them.

Levitan says that although "a 1700-bed nursing home," which is what PGH had become, is not needed in the city, "a 300- or 400-bed acute public hospital would be useful, to provide for patients who have no other recourse. If an institution is there, it's easier to glean support for it. The government can walk away from a responsibility to the private providers, which is essentially the case in Philadelphia. It is appropriate for charitable institutions to provide charity care, but it gets to the point

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The Charity Hospital at New Orleans, exemplary of United States public hospitals

when it's an insurmountable problem."

To Sigmond, "This city would be better off if PGH were still here. I do not believe in two-track medicine; I would work to enable private services to be provided to patients from the institution's service area. But there was a great tradition here, which represented the commitment of the city to health care in a way that a public health department does not. This is not to say that a city that has never had a public hospital, like Pittsburgh, should start one. But when there exists the tradition of the oldest public hospital in the United States—with a fine reputation—it is criminal to destroy it."

Other Cities, Other Scenarios

There are happier stories of closings. It is interesting that although some were accompanied by far more acrimony than the one in Philadelphia, their long-term results appear more positive.

New York City's public hospital system has closed several facilities in recent years, sometimes despite great community opposition, but it seems to have worked out. Jo Ivey Boufford, MD, president of the New York City Health and Hospitals Corporation, reports on the closing of five public hospitals—Delafield, Morrisania, Sydenham, Cumberland, and Greenpoint. "By and large," she says, "each was a case in which the facility had become physically obsolete." In addition, she points out, a replacement or equivalent facility was usually made available. The new, almost luxurious Woodhull Hospital was opened just as Greenpoint and Cumberland closed; the new (and later expanded) Harlem Hospital Center helped ease the closing of Sydenham.

Furthermore, she says, the city opened neighborhood family care centers to provide comprehensive outpatient services to patients of the closed hospitals. The idea appears to have worked better in New York than it did in Philadelphia. Boufford adds, "Constituencies in New York are very vocal and active. Any medically underserved community will be very concerned about loss of resources. The dialogue that has ensued around hospital closings thus has been successful—and patients are using the new facilities." There are no hard data, she says, but occupancy and utilization figures would indicate that the replacement facilities have gained acceptance. Also, in a city with 15 public hospitals, the loss of one is different from the closure of the only such facility in town.

There are other examples. Homer G. Phillips Hospital in St. Louis was closed in 1979 quite suddenly, leaving the pathetic picture of an older man standing on the steps of the closed facility, seeking his wife, who had been a patient there the day before. The closure caused enough political problems for the mayor that some observers cited it as a reason for his defeat in the 1980 elections. His successor pledged to compensate for the hospital's loss, and the area now has a public regional medical center that combines elements from closed city and county facilities—although it has financial problems of its own.

Other urban public hospitals have been transferred to private ownership, leased, or sold. What becomes evident is that there is no pattern, no one set of indicators, no overall point of no return. When you've seen one urban public hospital closing, as the joke goes, you've seen one urban public hospital closing. Despite the fears set off by the closure of Philadelphia General, relatively few city or county hospitals have been shuttered without replacement in the ten years since the demise of PGH. Those that have closed were usually "dead on their feet," to use Robert Sigmond's description of PGH at the end.

In fact, it seems that the best way to close an urban public hospital is to starve it first. As Bruce Vladeck, PhD, president of the United Hospital Fund of New York, has observed, "A full hospital never closes."

Closings Outside Cities

Rural public hospital closings have been less well documented than those in urban areas. Until recently, the closing of a hospital was seen as a sign of administrative failure, and was thus best completed out of sight. This is more easily done in rural areas than in media-minded cities.

A study by the American Hospital Association found that 22 state and local government rural general hospitals closed between 1980 and 1985, as did 24 public rural specialty hospitals. The closed general hospitals represented 1.7% of all rural general hospitals—a lower rate of closure than occurred in urban areas during the same period.

The authors of the study conclude that "rural hospitals may have a high degree of community support, may be one of the largest employers in the community, and may be viewed as an important element in attracting new individuals and industries to the area" (Mullner R, McNeil D: Rural and Urban Hospital Closures. *Health Aff* 1986;5[fall]:131-141). Furthermore, the authors conclude, many rural hospitals (public or private) are the only ones in the counties where they are located; therefore, every effort is made to retain them. Of the 85 rural hospitals of all types that closed between 1980 and 1985, the authors found, only six were in counties that were left with no hospital after the closure.—by Emily Friedman

Public Hospitals Often Face Unmet Capital Needs, Underfunding, Uncompensated Patient-Care Costs

ACCORDING TO THE 1986 edition of the American Hospital Association's *Hospital Statistics*, in 1985 there were 1616 state and local government-owned short-term general and "other" (excluding tuberculosis, respiratory disease, and psychiatric) hospitals in the United States. Their average occupancy was 62.8%—not significantly different from the national average for all hospitals. Although there were only seven public tuberculosis and respiratory disease hospitals left in the country, there were still 34 state and local short-term psychiatric facilities and 226 state and local long-term psychiatric hospitals.

Public hospitals continue to struggle with the burden of patients for whose care reimbursement is inadequate or nonexistent. A report by Dun & Bradstreet Credit Services in 1986 found that "state, county, and municipal hospitals saw the sharpest revenue drop of all [health care] industry segments" in 1985 (News at Deadline, *Hospitals*, 1986; 60[Nov 5]:17). A 1985 joint study by the AHA and the Urban Institute found that in 1982, public hospitals providing a high volume of bad debt and charity care sustained the largest deficits (averaging 14.38%) of any group of hospitals.

The Urban Institute also found that public hospitals share the problem of uncompensated care, no matter where they are located. Uncompensated care is defined as services provided to individuals who are either unable to pay (charity care) or from whom the hospital is unable to obtain payment (bad debt), along with other minor unreimbursed services. The institute found that in 1982, public hospitals in the 100 largest cities represented 5% of all US hospital beds, but 40.3% of all US charity care and 19.3% of all bad debt. Public hospitals in other metropolitan areas represented 6.8% of all US beds, 11.7% of charity care, and 9.5% of bad debt. Public hospitals in nonmetropolitan areas represented 9.5% of US beds, 3.4% of all charity care, and 7.5% of all bad debt. Overall, in 1982, public hospitals represented 21.3% of all hospital beds, 55.4% of all charity care, and 36.3% of all bad debt in the United States. In terms of equality of caseload, these institutions have remained in the backwash of the mainstream.

Editor's Note: This is the third of a four-part series on public hospitals. The final part will appear in next week's MEDICAL NEWS & PERSPECTIVES section.

A 1983 National Center for Health Services Research study, based on earlier (1977) data, found that in other ways, urban and rural public hospitals are quite different. Urban hospitals, the study found, "have larger percentages of ethnic minorities, younger patients, uninsured patients, Medicaid patients, obstetrical patients, psychiatric patients, patients with pneumonia, and patients with injuries from accidents or violence" than do urban voluntary hospitals (Coffey RM: *Patients in Public General Hospitals: Who Pays, How Sick?* National Center for Health Services Research, 1983).

Rural public and private nonprofit hospitals, on the other hand, were found to admit "nearly identical proportions of Medicaid patients; uninsured patients; medical/surgical, pediatric, obstetric, and psychiatric patients; and similar proportions of most age and diagnostic categories." The study also examined the severity of illness of patients in public and private nonprofit hospitals, using a form of the "disease staging" methodology developed for use by the federal Hospital Cost and Utilization Project. There was no clear-cut pattern

found. Diabetic patients in public hospitals were more severely ill, but patients suffering from diarrhea and gastroenteritis were less sick in these hospitals. Severity of illness was similar for both types of hospitals for other diagnoses.

Rural public hospital patients' severity of illness was found to be similar to that of rural private nonprofit hospitals. Public hospitals in rural and urban county alike shared one unfortunate statistic: lower birthweights and higher newborn mortality rates.

It can be concluded from these and other studies that rural public hospitals have become (if they were not from the beginning) mainstream community hospitals in many of the areas where they are located. The fact that many of these institutions are sole community providers has undoubtedly contributed to their level of acceptance. But few urban public hospitals have achieved that status yet.

Overall, however, says Larry Gage, president of the National Association of Public Hospitals (NAPH), "There is a great deal of support these days for 'safety-net' hospitals. Individuals in different parts of the health care field, for different reasons, recognize that until we fill in the gaps in health insurance, these hospitals remain necessary. The wolves are not out the way they were even a year ago, calling for closure of these hospitals or transfer of their functions to the private sector."

Urban Public Hospitals

The woes facing big-city public hospitals today can be summarized easily: unmet capital needs, mild to severe underfunding—and lots of business. In August 1986, the *Los Angeles Herald* reported that all six Los Angeles County hospitals were "filled to capacity" and "turning patients away." James Mongan, MD, executive director of Truman Medical Center, Kansas City, Mo, reports that on March 1, Truman opened the last 20-bed unit it has, and "our experience over the past four years has been that not long after we open beds, they are filled. Occupancy is currently 94.5%." Overall hospital occupancy in the city, he says, is 62%.

Donald Anderson, MD, director of Parkland Memorial Hospital, Dallas, reports the same situation: "We don't have any place to put more patients; we have to divert ambulances to other hospitals until we have beds available." Even in New York City, where municipal hospital occupancy has traditionally been lower than that of private hospitals, systemwide Health and Hospitals Corporation facility occupancy is 85%, and psychiatric beds were operating at 4% above capacity in August 1986. Dennis Andrulis, PhD, director of research and policy for the NAPH, reports that urban public hospitals in mid-1986 had an average occupancy of 79.5%—well above the national rate for all hospitals, which was 64.7%.

Emily Friedman

Philadelphia General Hospital, after its closing in 1977

This is not the first time that crowding has plagued urban public hospitals; in the 1920s and 1930s, it was a chronic problem in Chicago, Baltimore, Washington, DC, and elsewhere. The reason then was the same as the reason now: patients who cannot pay, and a decline in the ability and/or willingness of private hospitals to care for them. In the 1930s, it was the Depression and unemployment; today, it is a more price-conscious health care market, low Medicaid payments, and the growing army of uninsured Americans, which the Census Bureau estimates has increased by more than 40% since 1980.

Urban hospitals also continue to play a key role in the provision of hospital outpatient care. In Chicago, for example, Cook County Hospital has 7% of the beds, but provides 16% of all hospital outpatient and emergency department visits in the city. Grady Memorial Hospital in Atlanta has 19% of the beds but provides 75% of the city's total hospital outpatient and emergency department visits. Jackson Memorial Hospital in Miami has 23% of the beds, but provides 43% of hospital outpatient and emergency department visits.

These figures are silent testimony to the continuing need for services traditionally provided by these hospitals: trauma and other emergency services, such as burn and neonatal care; serving as "family doctor" to those who for whatever reason cannot or do not seek care from private physicians; and refuge for those with sociomedical problems, such as persons who live on the street. A sample of 23 urban public hospitals surveyed by NAPH, Andrulis says, reported that nearly 52% of their outpatient and emergency department visits were related to care of the indigent. That averaged out to 122 000 such visits per hospital.

Public teaching hospitals in the 100 largest cities appear to be having particularly tough times. According to a 1985 Commonwealth Fund report, public teaching institutions in the 100 largest cities had an aggregate negative revenue margin (−1.5%) in 1982, whereas nonteaching public hospitals had a positive total margin of 2.9%. The teaching facilities also were more likely to have a negative operating margin (45% did) than public nonteaching hospitals, and reported higher rates of uncompensated care than private urban hospitals.

These aggregate figures do not fully illustrate the fact that some states and localities are facing lean times and are hard pressed to keep up with their hospitals' mushrooming operating deficits. In Texas, hard hit in recent years by the faltering of the oil economy, the figures are grim. In 1981, for 11 hospitals in the state subsidized by government units (ten public, one private), the average shortfall per hospital between subsidy and uncollected revenues was $5.6 million. By 1983, the gap had swollen to $17.1 million. Anderson reports that at Parkland, the gap was $7 million in 1982, $11 million in 1983, $14 million in 1984, $19 million in 1985, and $20 million in 1986. The Charity hospitals in Louisiana, which are state-owned, must compete with other services for scarce dollars in a state whose economy has collapsed along with oil prices. In California, Massachusetts, and elsewhere, taxpayers' revolts have led to ceilings on local property taxes.

Capital, whether for operating purposes or for physical plant and equip-

ment improvements, is harder to come by today for most hospitals; it is even more difficult for public facilities. Aging plants in Chicago, Boston, Houston, Washington, DC, and many other cities pose difficult dilemmas for strapped governments.

However, the situation appears brighter than it did a few years ago. There is renewed interest and media support for a new Cook County Hospital, although the traditionally byzantine politics of Chicago have prevented previous replacement proposals from being implemented. The city of Boston has received planning permission to replace Boston City, and the voters of Houston have approved replacement of both of that city's municipal facilities, Ben Taub and Jefferson Davis Hospitals. This new wave of proposed capital expenditure comes after a decade of inactivity; five years ago, Denver General Hospital, which was built in 1972, was the last urban public hospital for which voters had approved replacement bonds. They did so in 1965.

There is less talk of closings today. Denver General was put up for sale briefly in 1986, but that appeared to be more a political gesture growing out of haggling over the hospital's finances than a genuine offer. It was not sold. And since 1980, say Sager and Andrulis, there has been little activity in terms of the closure of major urban facilities. With the exception of the merger of the two St Louis hospitals, the transfer of the Detroit-area Wayne County Hospital to a private consortium, and the placing of University Hospital in Louisville under the nearly complete control of the Humana proprietary health care chain, most urban hospitals appear to be weathering the storm—if only barely.

Rural Public Hospitals

According to Robert Van Hook, executive director of the National Rural Health Association, there are approximately 1500 rural public hospitals today. They are often the sole providers in the counties in which they are located, and are therefore more essential, in some ways, than the urban public hospitals. But these facilities have problems of their own. For one thing, says Van Hook, rural economies are increasingly fragile, and hospitals dependent on local tax bases are feeling the effects of that. "In the Midwest, for example, rural land values rose sharply in the 1970s and early 1980s; those values have now declined by approximately 50%. That is eroding the tax base upon which rural public hospitals are dependent."

Furthermore, says Van Hook, the national pattern of declining inpatient utilization is even more pronounced in rural hospitals, which have experienced at least a 16% decline since 1980. And rural hospitals face an even tougher capital acquisition situation than urban hospitals do. Donald Dunn, president of the Iowa Hospital Association, also cites the "inequitable, unfair Medicare prospective payment system that discriminates against rural hospitals." Of 128 hospitals in the state, he says, 65 are publicly owned; and most are suffering from inadequate Medicare reimbursement.

Dunn says he predicted that several of these hospitals would close in 1985 and 1986, yet only two have. Why? Iowa public hospitals have proven extraordinarily adept, he says, at diversifying into activities that produce enough revenue to keep them going. Also, as long as community support holds, there is some relief in the form of tax revenues.

That will not last forever, however, according to Melissa Hungerford, vice-president of the Kansas Hospital Association. In that state, 44% of all hospitals are publicly owned. Kansas law requires that any tax levy greater than 2 mills be approved by referendum, and "more and more hospitals are seeking to go above that level," Hungerford says. Occupancy is very low throughout the state, she reports; many hospitals have five or fewer inpatients per day, and many more have ten or fewer. Still, only one public hospital has closed recently.

In Washington state, where there are 37 rural public hospitals, most of them operated by hospital districts, the same pattern holds, according to Victoria Galanti, vice-president of the Washington State Hospital Association. She reports the closing of only one district hospital—ten years ago. However, hospitals are facing low occupancy, unfulfilled capital needs, and limited taxing power resulting from a ceiling on property taxation. Hospitals often must compete for the same tax dollars sought by schools, library districts, and fire departments, according to Leah Kliger, executive director of the hospital association's Rural Health Project.

On top of all that is the indigent care problem. Kliger says that of the ten hospitals in the state with the largest proportions of their caseloads represented by care of the indigent, nine are rural. She believes that "probably a quarter of the rural district hospitals in the state are seriously considering closing down inpatient services and instead providing ambulatory, emergency, and long-term care. I think we will lose a number of them as inpatient facilities in the next five years. This is true in Alaska, Montana, and Idaho as well; I wouldn't be surprised if it were the case in most rural areas."

Dunn concedes that "not every rural public hospital needs to survive in order for the public to be served well. However, there does need to be continued geographic and financial access to care for people who live in rural America," who still represent 25% of the US population. Dunn sees the rural public hospital as essential to the "infrastructure" of the rural community, and fears that without these institutions, "the community will have trouble retaining its business and industry, its educational structure, and its medical manpower."

California: Is This the Future?

The traditional view of California as a bellwether state is not always accurate, but the situation of public hospitals there may provide some clues as to the future of government institutions elsewhere. California has 58 counties. In 1960, those counties owned 65 hospitals. Today, there are 31 county hospitals in 24 counties. Those 24 counties represent 70% of the state's population, and another 19% of the population is in counties where former county hospitals are now teaching facilities owned by the University of California. Still, 34 county hospitals were closed, sold, or otherwise disposed of in 25 years.

A number of factors contributed to the decline. First, the California Medicaid program, known as Medi-Cal, has traditionally been more generous than most, covering more than half the state's poverty population. Thus the 1965 Medicaid enfranchisement contributed to a decline in the use of county hospitals. Also, in 1971, the then-governor, Ronald Reagan, enfranchised some 300 000 medically indigent adults (MIAs) under Medi-Cal. As health care for these persons had previously been the responsibility of counties, this action reduced the number of needy individuals for whom counties were required to sponsor care.

Furthermore, the 1960s and early 1970s were a time of public-private partnership; many counties sought to divest themselves of costly and often cumber-

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Postage stamp issued in 1986 in honor of public hospitals (*JAMA* 1987;257:1437-1444).

some hospital responsibilities. California is also home to a number of proprietary and nonprofit health care chains that own and/or manage hospitals; as they became a presence on the health care scene, some county governments were attracted to the idea of contract management or lease of their hospitals. Between 1973 and 1980, 15 California counties signed contracts for the management of their public hospitals by private firms.

The trend of divestiture and contract management has slackened considerably since 1980, again reflecting changes in the California health care environment. Beginning in the late 1970s, that environment became increasingly competitive. With an ample physician supply in many areas and an outright oversupply in some (such as the San Francisco metropolitan area), an equally ample supply of hospital beds, and a host of alternative delivery systems entering a market traditionally dominated by the Kaiser-Permanente HMO, the state was ripe for sharp bargaining by employers and health insurers.

That process was greatly enhanced by passage of legislation in 1982 that made selective contracting possible. The first two organizations to take advantage of this were the Medi-Cal program and Blue Cross. That same legislation also remanded responsibility for 270 000 MIAs back to the counties—along with 70% of the funding the state had been providing for their care under Medi-Cal. All this was played out in the context of Proposition 13, which had severely limited the ability of counties to raise property taxes.

What happened to county hospitals was not surprising. As Charles White, PhD, then senior vice-president of the California Hospital Association and now an executive with Grossmont Hospital in San Diego County, observed in 1984, "In 1982, county hospitals had about 49% Medi-Cal patients, including MIAs. A year later they had 36% Medi-Cal patients—and an identical increase in MIAs from 36% to 49%. They lost paying patients and got basically unsponsored [uninsured] patients in return. Of all bad-debt and charity care in California hospitals, 65% is now concentrated in county hospitals. If you want to know the future of county hospitals, there it is" (Friedman E: Medi-Cal Contracting: Model or Mayhem? *Hospitals* 1984;58[Aug 1]:74-78).

As for contract management, the evidence so far "is discouraging," says Thomas Rundall, PhD, associate professor at the University of California-Berkeley School of Public Health, who has studied the situation. "The evidence on contract management suggests that expenditures increase, rather than decrease, and that there is no increase in the quality of care provided, at least in terms of the variables we used—although there does not appear to be a decrease, either. Therefore, there are no savings to the system, and services to the users of these facilities have not improved."

Rundall adds that several counties have opted for capital and service improvements at their hospitals, hoping to attract more private patients; some facilities have even been renamed, and some innovations have been introduced, such as the HMO based at the Contra Costa county hospital. However, he says, in a state with an overall hospital occupancy of 57.2%, it is unlikely that county hospitals will be able to lure many private patients away from the hospitals they now use.

County hospitals in California today are at "a watershed point," according to Carol Emmott, PhD, executive director of the California Association of Public Hospitals. "Their fiscal health, from an operating perspective, is adequate at present, but it is a hair away from being inadequate. Their capital financing has been inadequate for decades. Los Angeles County-University of Southern California Medical Center and many other county hospitals can date their physical plants back to the 1920s. Yet public facilities are capitalizing themselves at a rate 86% lower than that at private facilities."

Meanwhile, continued cuts in Medi-Cal have a profound impact on county hospitals, "40% of whose operating budgets come from Medi-Cal," Emmott reports. "County hospitals," she adds, "represent 5% of the state's hospitals and 11% of the beds. Yet in the 24 counties with county hospitals, those facilities provide 44% of the state's Medi-Cal care and 60% of all bad debt and charity care." As a result, she says, "Many county hospitals are effectively full and are turning away literally hundreds of nonemergency patients each month to whom they would like to provide care. The county hospital's role as respository for the uninsured and the underinsured has reached the saturation point. We are now anticipating severe access problems."

Is this what other public hospitals can look forward to? Rundall thinks so. "The situation in California is a bellwether for the rest of the nation. We have seen the face of the American health care system for the rest of the century in this state. It is characterized by less freedom of choice, lower reimbursements to providers—hospital and physician alike, competition for insured patients, and an erosion of the safety net we have come to rely on since 1965."

—by Emily Friedman

Problems Plaguing Public Hospitals: Uninsured Patient Transfers, Tight Funds, Mismanagement, and Misperception

PUBLIC HOSPITALS today face serious problems. Four types of troubles seem paramount: transfers of uninsured patients from other providers, growing unavailability of working and building capital, the perceived or actual obstacles created by public ownership, and the lingering image problems born in the almshouses of centuries past.

Transfers: "A Strange Symbiosis"

Although the more genteel term is "economic transfers," house staff and public hospital advocates have long called it "dumping"—the practice of sending uninsured (and, in some cases, Medicaid-eligible) patients to public hospitals solely for economic reasons. "Dumping" is defined in many ways: transfer of unstabilized patients; transfer of patients who are stabilized; transfer of patients already admitted, in the middle of a hospital stay, because their insurance coverage has run out or has been found not to exist; or transfer of patients through organized or even formal arrangements. The key ingredient is the patient's lack of public or private health insurance.

It is not a new phenomenon. Charles Rosenberg, PhD, a historian at University of Pennsylvania, Philadelphia, points out that "in the period from 1850 to 1870, the scandal of which voluntary hospitals were most afraid was that resulting from the death of a patient in an ambulance during a transfer to a municipal hospital. The newspapers would reveal the transfer, and because everyone assumed that private hospitals had public responsibilities, it would be seen as inhumane. But from the beginning of the 19th century, when voluntary hospitals were first established, they had the ability to define which patients they did not want to treat: the chronic and incurable, the 'morally unworthy,' alcoholics, patients with venereal disease. Many of them would not take children, either, or pregnant women seeking hospital rather than home care, because they were usually prostitutes. It has been a strange symbiosis between the public and private sectors."

Today, however, the symbiosis is a source of strain. Parkland Memorial Hospital, Dallas, received national attention for implementing tough policies to discourage the improper transfer of indigent patients; Jackson Memorial Hospital in Miami has also caused controversy (and has been sued by other hospitals) because of its stringent transfer policy. Donald Anderson, MD, Parkland director, points out that public hospitals in Texas, like most county hospitals, are not reimbursed for every unsponsored patient they treat; even the uninsured must meet residency and income requirements to qualify for reimbursement. Many transfers received at Parkland and other public hospitals, Anderson says, "fell way outside these mandates."

Editor's Note: This is the last of a four-part series on public hospitals. The other installments have appeared in the three preceding issues.

However, Parkland is monitoring and challenging improper transfers, Anderson says, more to ensure the safety of patients than to reduce transfer volume. The problem is that Parkland is at full capacity, as are many other urban public facilities. Observes Henrik Blum, MD, emeritus professor of the University of California-Berkeley School of Public Health, "The public hospital serves as the last resort for the desperate, who are being dumped by other facilities. And now those patients can't even get dumped! I can't think of anything more awful."

When public hospitals divert ambulances to other hospitals, the private sector calls the practice "reverse dumping," but there are few options in such a situation. What bothers Anderson, he says, is that "I could go bowling in some of the other hospitals in Dallas and not hit a patient. They are closing down beds, laying off staff. We would like to use their excess capacity, but we can't." He reports that when he offered other hospitals $1200 for a normal delivery (Parkland's costs for the procedure are approximately $850), there were no takers.

If patients are transferred safely, and if there is room for them, it can be argued that the public hospital is the appropriate site for their care (although private hospitals holding tax-exempt charitable status could certainly be expected to provide some care to the indigent). "It's entirely inappropriate to transfer an unstable patient, and in almost all circumstances it is inappropriate to transfer a patient once treatment has started," says James Mongan, MD, executive director of Truman Medical Center in Kansas City. "But we see many patients who self-refer, because they know they will be treated here if they do not have insurance. We also receive referrals from physicians' offices of patients who do not have insurance. I do not consider either of these to be 'dumping.' That's what we receive tax support for; that's part of our mission."

John Sbarbaro, MD, vice-president of St Anthony Health System, Denver, who resigned his post as deputy manager of the Denver Department of Health and Hospitals in 1986 after 21 years, says, "I think that patients who end up in a private institution, who meet the criteria for care in a public hospital, should be transferred to a public hospital. To ask private hospitals to cross-subsidize the costs of care of these patients at a time when payers are prohibiting such cross-subsidization can threaten those hospitals' existence. If we have a public problem, we should address it in the public sector. Otherwise it's like asking a private security firm to do the police force's job."

The problem, of course, is what happens when patients are being transferred or referred to hospitals operating at more than 100% capacity—or what

happens when tax subsidies reach their limits. The debate over dumping will likely continue as long as there are public hospitals in metropolitan areas.

Capital Availability

Declining revenues are a problem for many hospitals; even those with positive profit margins. The problem is just exacerbated for public facilities. Larry Gage, president of the National Association of Public Hospitals, says, "Whether or not capital will be made available to older hospitals will be a matter of the commitment of local elected officials. I do not see that commitment decreasing."

On the other hand, says Jay Wolfson, PhD, associate professor of health care finance at the University of South Florida, "I think public hospitals have to be worried about their sources of working capital, because they don't have the flexibility to borrow money the way other hospitals do. I think they will have to learn to become more aggressive financial managers; if a patient can pay a bill, he should pay it. Even in the recent past, many public hospitals did not have in place the most basic financial management systems, even for determining insurance coverage or Medicaid eligibility. That is starting to change."

There is also heartening evidence of a renewed commitment to these hospitals on the part of governments. Many states are trying to expand Medicaid coverage, especially of pregnant women and young children, through liberalizing eligibility criteria; this will increase revenues for many public hospitals. In 1986, Congress passed a provision allowing states, at their option (and without federal matching funds) to provide Medicaid benefits to pregnant women and young children with incomes below the federal poverty line, regardless of whether they qualify for welfare.

Congress has also passed a requirement that hospitals treating a "disproportionate share" of low-income, publicly sponsored patients be paid higher Medicare rates. Similar provisions had been passed before, but Medicare authorities had been reluctant to comply, claiming that such hospitals had not proved their contention that their expenses were higher because of their caseloads. The new provision, Gage says, is "idiot proof."

But in the age of the taxpayer revolt, the problem of capital availability will continue to hinge on the ability of governments to convince taxpayers that public hospitals (which most property owners may never use) deserve more support.

Perils of Government Ownership

Generally speaking, governments have not distinguished themselves as streamlined, efficient managers of institutions. Too many barriers are embedded in the matrix of bureaucracy. However, says Gage, the problems of public ownership may be overestimated. "Local politics are local politics," he says, "but many public hospitals are organized in such a way that politics are kept out of day-to-day operations. It is not generally appreciated that most public hospitals report to officials who have city or county cabinet-level positions. Many of these hospitals have independent boards, even if some are only advisory. Political problems have never been very bad for two thirds of the urban public hospitals in this country. For the other third, politics are a thorn."

Even in the notoriously rough-and-tumble world of Chicago politics, however, the situation is only complicated, not impossible. Elliott C. Roberts was executive director of Cook County Hospital between 1980 and 1984, and he sees advantages in government ownership, even when a large hospital is governed by the county board: "The closeness of the operating forces within that institution to the recipients of service is remarkable. A patient could attend a county board meeting and be heard. They are not only heard; they are listened to. There is accountability, in at least some of these situations."

Sbarbaro suggests another reason for government to operate hospitals: It allows more organized resource allocation. "It's more acceptable to prioritize in the public sector. People expect it. As the public health care dollar becomes more scarce, we are going to force physicians and hospitals to prioritize patients by the severity of their need. In any economic recession, the number of people without health insurance rises. Industry tries to reduce its costs by reducing employee coverage, or eliminating it entirely. Where can these disenfranchised patients get care? Private hospitals and physicians are no longer capable of handling all the load, and they must put up barriers to access in order to deal with unlimited demand for free care."

Public hospitals, he says, allow government to cope with that demand. "With a public facility, government knows what it can spend. It can dictate the number of beds, of physicians, of nurses that it will have available. It gives the physicians a set amount of resources and tells them to use them wisely and well—to prioritize. In such a system, obviously, mistakes will be made. Occasionally a patient who has a headache, who had to wait while a patient with a major knife wound was cared for, will turn out to have meningitis. That happens when physicians must prioritize care.

"But should a mistake be made in the prioritization process, and should that mistake lead to litigation, the physician is protected. Most physicians in the public sector are protected by government immunity. The judge will say, 'This was a clear, thoughtful process of prioritization, and the problem was a limitation of resources over which the physician had no control.' Thus only in a public institution, with the immunity provided by government ownership, can a physician feel comfortable in prioritizing care and allocating dollars to those who are in the greatest clinical need. The public hospital physician is the most secure of all physicians; he can make the best decisions possible in the context of real limits—but government takes responsibility for what those limits are."

This type of prioritization, Sbarbaro says, "is the key difference between public and private hospitals. In the private setting, there is an expectation that all perceived needs—real or not—will be met, based on the public perception that unlimited resources are available in the private sector. In the public sector, too, some demand is based on need that is more perceived than actual. Prioritization eliminates much of the care that might otherwise be provided in response to reported but nonexistent need, because these patients must wait in the back of the line of priority. Real needs are met, and those with only perceived need will often go away, having decided that their needs are not so great when seen in the harsh light of a long wait for care. Unfortunately, a few patients fall through the cracks and

suffer harm; but for the most part, it works. In the end, the collision of unlimited demand with a fixed resource can only be managed in the public sector."

Is this not rationing of care and abandonment of accountability? Actually, says Sbarbaro, "It is rationing with accountability. If a mistake is made, or if resources are insufficient, then the public mechanisms—the press, the legislature, and the courts—can call the executive branch to account and say that more resources must be shifted to health care."

The entire question of accountability in government ownership of hospitals is sometimes more clearly seen in rural areas, says Kliger. "People who serve on hospital district boards are community residents with a sincere interest in the institution. There is real accountability through this mechanism. These hospitals are in some ways more accountable than others because members of their boards are accountable to their peers. The mechanism can be abused, however, by splinter groups and those with private agendas."

The encumbrances of government, as well as the desire to "get out of the hospital business" that many public officials express, have led some to seek commercial help in the management of their hospitals. Nationally, as in California, it has proven a mixed experience. Liston Witherill, senior vice-president of Nu-Med, Inc, a proprietary health care firm in California, served as director of health services for Los Angeles County from 1972 to 1977, so he is familiar with both sides of the fence. His firm manages several public hospitals.

"My experience," Witherill says, "is that public hospitals that hire management firms either face financial problems of crisis proportions, or else need capital to replace an outmoded facility." In the past, some management organizations, he says, purposely submitted unrealistically low bids for management contracts because they wanted to acquire the hospitals. However, "the market for management services died. Also, the revenue from management contracts was less than what firms could realize from owning hospitals, although that has changed recently because of reimbursement constraints."

Witherill believes that there are certain indications for either management or broad consulting contracts: financial crisis, severe medical staff problems, loss of accreditation, the need for capital. Otherwise, he says, "I don't see any need for contract management if the institution is running reasonably well." The effectiveness of this approach was evaluated by Thomas Rundall, PhD, University of California, Berkeley, associate professor, and Jeffrey Alexander, PhD, in a 1980 study. "Expenses per patient day and operating revenue per patient day were found to increase under contract management," they reported (Alexander J, Rundall T: Public Hospitals Under Contract Management. *Med Care* 1985;23:209-219).

Also, they observed, "The primary benefit of contract management arrangements is not to streamline or improve the performance of hospitals so much as it is to enable hospitals to cope better with external pressures such as regulation." They concluded, "Boards of public hospitals entering into contract management with the hope of quickly reducing expenditures and increasing revenues may be disappointed."

Rundall and Alexander also suggested that contract management firms may "carefully choose the hospitals they enter into management agreements with," thereby increasing the chances of profitability. Although this is a perfectly reasonable approach, it also means that hospitals in truly desperate straits—which might benefit most from such arrangements—are unlikely to be attractive candidates.

Another option is to transfer control of public hospitals to private hands. As Harry Dowling, MD, a public hospital historian, asks, "What better solution than to give the costly, troublesome, constantly complaining, unattractive, unloved brat to someone else to rear? Even politicians, never likely to give anything away without something in return, were attracted to the idea" (Dowling, *City Hospitals*). Among cities or counties that have transferred hospitals to private and/or nonlocal control since 1964 are San Diego; Detroit; Seattle; Kansas City, Mo; Toledo, Ohio; Newark; Louisville; and Wayne County in Michigan.

It can be successful, as appears to have been the case with Detroit General Hospital (formerly Detroit Receiving Hospital). By the early 1970s, its aging plant required replacement. A new hospital, eventually to be known as Detroit Receiving Hospital, was built on the campus of the Detroit Medical Center, a consortium of private hospitals in downtown Detroit. A task force charged with determining the fate of the new hospital decided that it would be better off in private hands, given cumbersome city procedures, extremely generous wages and benefits for employees, and other constraints that came along with public ownership.

A complicated arrangement was worked out with the medical center hospitals, whereby Detroit Receiving would be the trauma center for the consortium, accepting (as did the others) all patients and referring them among medical center hospitals only on the basis of diagnosis. Romantic as it sounds, it worked, according to Symond R. Gottlieb, executive director of the Greater Detroit Area Health Council. "My impression is that although it has been a drain on the private hospitals, which are among the area's largest Medicaid and uncompensated care providers, they seem to have been able to handle it so far. Detroit Receiving was on thin ice financially until very recently, but it appears to have achieved more solid footing."

He warns, however, that this may not be a replicatable model. The transition was accomplished at a time when there was more reimbursement and less price competition among hospitals than there is today. Also, he says, "The private hospitals involved were well-established and had a long charitable tradition. Even in the current, tougher marketplace, they still want to carry out their mission of service to the poor. This transfer was built on the basis of that. It might not work elsewhere."

He points out that the transfer several years later of Wayne County Hospital in suburban Detroit to a hospital with roots in the inner-city black community has been less successful; the former county hospital, now known as Westland Medical Center, is in grave financial condition.

Echo of the Almshouse

The other major problem confronting public hospitals today, at least in metropolitan areas, is that they are often viewed as residual providers—the hospitals of last resort. There are excep-

tions, of course; urban public hospital trauma centers are often superb. Blum says: "Even private physicians, if they are hit by a car, will seek care in the public hospital." But the "centers of excellence"—trauma, burn, and neonatal care, as well as exceptional teaching services and outpatient care—are too often submerged in a sea of social prejudice and mediocre management.

Part of the trouble is the confusion of mission bred by the heterogeneous charges these hospitals try to honor. Says Wolfson, "They are trying to accomplish their mission of service to the indigent while at the same time trying to attract paying patients. This creates a conflict of motive, of environment, and of priority. The heart transplant center vies for attention with care of the homeless. It's not impossible to overcome, but it can aggravate the image problem." The public hospital may have left the almshouse 200 years ago, but the taint of the undeserving poor is still detectable.

The problem goes back a long way, says Rosenberg. "A hospital has two functions; one is human and the other is technical. One of the ironies of the situation is that many 19th-century public hospital reformers were medical men. Their reforms turned on making the institutions more or less exclusively technical and more and more dominated by physicians. They succeeded—but what they created was still 'the lower-priced spread.'"

Those most concerned about the image of the public hospital as a second-rate institution generally fall into two groups: those who work in or on behalf of these institutions, and those seeking to increase revenues by increasing the flow of private patients. The former group has ample ammunition to back its cause. Although the amenities in public hospitals—private rooms, attractive food, individual television sets, private nursing care, and similar services—can rarely compete with those in private settings, there is scant evidence that the clinical quality of medical care provided is less than that in most private institutions.

A recent study of accreditation in public and private hospitals in New York City, for example, found that on the basis of the standards of the Joint Commission on Accreditation of Hospitals, the municipal hospitals did marginally better than the private facilities (Hyman H: Are Public Hospitals in New York City Inferior to Voluntary, Nonprofit Hospitals? *Am J Public Health*, 1986;76:18-22).

The second group—those who hope public hospitals will directly compete with private ones—are likely to be disappointed. In the privately oriented US economy, public services—be they schools, transportation, or hospitals—are not likely to shake the deep belief of Americans that what is public is almost automatically inferior. And perhaps things are better left that way. For if it is believed that the unwanted are receiving care that is somewhat less than that reserved for higher echelons, that belief may satisfy the continuing American need to somehow segregate the deserving from the undeserving poor without causing grievous harm.

What Are They Needed For?

Today, the rural public hospital is needed, in most areas, in the same way that any rural hospital is needed: to be the core of health care services in the community. It is likely that more of them, in the future, will not offer inpatient services, but will continue to provide enough of an anchor to keep physicians in town and to answer community needs for emergency, ambulatory, and chronic care.

The urban public hospital is often needed because it provides three key services: care of the vulnerable, training of physicians and other health care professionals, and provision of certain services that other institutions cannot, will not, or should not be required to offer.

In terms of the first charge, Rosenberg notes, "There was a period during the 1970s when it was thought that public hospitals would become extinct. But it has become clear that the social burden is intractable—and that municipal hospitals have always borne an unfair part of that burden."

Mongan adds, "I would like to envision an ideal world in which such hospitals were not needed, in which every patient had a source of payment and therefore had access to any facility in town: a world of one-class health care. But we aren't going to get there. Even if we did, there would be patients whom the private hospitals would not be comfortable treating—society's undesirables: the homeless, street people, addicts, prisoners, and others."

As for the teaching mission, Richard M. Knapp, PhD, director of the Department of Teaching Hospitals of the Association of American Medical Colleges (AAMC), Washington, DC, reports, "Almost half the colleges of medicine in this country have a predominant reliance on a publicly owned institution to carry out their education and training programs and clinical research." The public hospitals involved include 39 under common ownership with a university, 25 municipal hospitals that serve as primary teaching sites for medical school programs, and many more city and county facilities that serve as "affiliated educational institutions." These figures exclude Veterans Administration and military teaching institutions, which put the overall total even higher.

The days of the free-form specialty residency in the almshouse are gone, but ties between public hospital and medical school remain. They are not without problems. Increasing competition for patients and growing pressures on faculty members to produce revenue breed tension. The motives of a teaching service may conflict with the requirements of the constituency; a new program may have to be delayed in favor of expanded routine services.

"How well these arrangements work is a matter of cultural and political anthropology," Knapp says. "The role of the faculty at the college of medicine has been an issue over the years, and as long as that faculty took only referral patients and provided services to those who couldn't pay, town-gown relationships remained positive and stable. Now, in some localities, those relationships are starting to fall apart, because there is competition for the paying patient between the faculty and the community physicians."

As for public university teaching hospitals, John Colloton, director of the University of Iowa Hospitals and Clinics and chair-elect of the Association of American Medical Colleges, says, "For the most part, these hospitals are not subsidized. They function in the same milieu as private teaching hospitals. As competition evolves, and third-party payers are unwilling to perpetuate the traditional system of paying for the educational costs as a component

of patient charges, public as well as private teaching hospitals will have to find separate financing channels."

He believes they will, especially through government subsidy: "When teaching hospitals demonstrate the aggregate contribution they are making to society, as well as their high quality and the continuing need for their services, ways and means of financing them will be found." It is probably true of his institution, which is widely viewed as unique; 60% of family practice residents trained there remain in Iowa, as do 40% of other specialists. Other institutions may have to work harder to prove their merits to skeptical governments.

The individual advantage of training in a public hospital is the opportunity and drama provided by what Anderson terms "resurrection medicine"—saving the life of the last-minute, grievously ill patient. Dowling describes public hospital residency as "a frenzied war dance of life against death" (Dowling, *City Hospitals*). It educates the resident about waste and shortsightedness as much as it does about medicine; and it may, in a terribly backward manner, teach something about the value of preventive medicine and early intervention. But train it does, and as Rundall observes, "I see no alternative to the public hospital as a primary training ground for physicians."

Finally, there is the special service mission, which encompasses everything from that which is expensive (care of burns, trauma, and AIDS) to that which is best centralized (care of prisoners and of those who may pose a danger to themselves and/or others). These are duties traditionally, and probably appropriately, left to the public hospital.

Other duties that have been similarly delegated may prove, in time, to be a competitive advantage. Jo Ivey Boufford, MD, president of the New York City Health and Hospitals Corporation, points out that public hospitals historically are skilled in certain kinds of care that have "filled in the gaps in the rest of the system, such as acute psychiatric care, women's health, outpatient services, and long-term care." In an aging nation whose health care system needs to be reconfigured, she says, "These forms of care will become more mainstream—and public hospitals will be better prepared to provide them."

Will the public hospital survive? Blum, a former county health officer, thinks so, although he wishes it were otherwise.

He sees the public hospital as "a poverty-segregated entity that, given the economics of various demographic groups, also becomes a largely racially segregated entity. These hospitals are powerless because they have a powerless constituency, and are seen as a drain on the public purse by many politicians." In addition, he says, the public hospital is caught in the endless "teeter-totter" of government finances: when times are flush, the hospital is needed less because more patients have jobs, and thereby health insurance, and public hospital occupancy goes down. The hospital contracts. When hard times come, the tax base shrinks and the government is ill-equipped to properly fund the hospital when it is most needed. "You lose patients every time," he says. "The system is a disaster."

He prefers "mainstreaming" patients into organized systems such as HMOs, where private patients are also treated. However, he does not see this or any other solution coming to pass until the plight of the public hospital and the crisis of medical indigence become "a major national scandal." At that point, he predicts, a universal entitlement of some type will be enacted. Would public hospitals still exist, were there universal coverage? "Even without the indigent care mission, the majority of these hospitals would still be in place," Gage says. Sbarbaro adds, "Public hospitals have been around in this country for 250 years, and if we're smart, we'll keep them around. If they are closed, their patients will go to private hospitals, mostly university hospitals, which we will then ask to do precisely what the public hospitals were doing. We'll end up burying the university hospitals."

"I think there will be public hospitals in 2010," Mongan says. "The question is, what kind of shape will they be in?"

In his musing on the new building into which Bellevue moved in 1975, New York University professor of medicine Gerald Weissman, MD, who has worked at the hospital for many years, observes, "The infective insults of streptococci and tuberculosis are abetted by poverty, dirt, and urban crowding—what the young leftists of the 1970s called 'diseases of oppression.' And since there is little evidence that these social imperfections have been ameliorated, newer diseases of the underclass have begun to replace the old. . . . We now find our wards filled with cases of AIDS, 'brown heroin kidney,' 'gay bowel,' oral chancres, gonococcal arthritis, the hepatitis of drug abuse or pederasty, the endocarditis relayed by infected needles, and the acute respiratory distress that follows a jet of flaming cocaine. . . .

"On the quiet corporate floors of the new hospital tower, the professional middle class (students, house officers, attending physicians) sorts out the ranks of those wounded in our social wars. The mugged, maimed, drugged, and infected are victims of epidemics as virulent as those that filled the gracious loggias [of the old Bellevue] of 1908. The high-rise columns and modular panels of corporate architecture now house the losers of new urban scrimmages, for whom there is no place in the similar towers of Wall Street or midtown. In both the old Bellevue and the new—and for this reason there is perhaps no more engaging hospital in which to work—we have been able to appreciate not only *what* happens in disease, but also to *whom*" (Weissman G: Bellevue: Form Follows Function, *The Woods Hole Cantata*. Boston, Houghton Mifflin Co, 1985).

Perhaps it will always be thus; perhaps public hospitals have not moved so far from their first purpose, and perhaps they should not. As Emmott says, "We have an obligation, as a society, to those who are unable to fit into the mainstream. I would prefer that we intervened in a more preventive way to help them fit in, economically and socially; but as long as we do poorly in that regard, we at least have a duty to try to heal their fractured bodies when all the other inadequacies of their lives break them." Beyond all the romance, the public-private ideological scraps, the hope for alternatives, and the advocates and attackers, the little rural hospital and the urban landmark alike remain a part of the American medical landscape, serving—often superbly—until something better comes along. "We are moving away," says Alan Sager, PhD, associate professor, Boston University, "from a polarized debate that says that public hospitals are either angels or devils. They are neither; they are merely essential." —by Emily Friedman

Our Nation's Great Public Hospitals

In recent years, health policy analysts and decision makers have increased their concern over the plight of uninsured patients, uncompensated care, and the changing complexion of the nation's health care system.[1-4] This period, however, has seen far less attention focused on the fragile, nationwide network of great public hospitals that already provides those health services—the institutions that serve in effect as America's national health insurance by default. While the Congress has sought repeatedly in the last several years to require extra attention in the Medicare and Medicaid programs to the need of such hospitals, it is only in the last several months that the Reagan Administration has finally been forced to provide such relief (1986 Consolidated Omnibus Budget Reconciliation Act [COBRA] Public Law 99-272). (See Gage L, Newman H: Lawsuits, legislation mean federal relief for ailing hospitals. *Legal Times* 1987;9:14-16.)

The series of four articles on public hospitals that is completed in this issue of THE JOURNAL is therefore a welcome effort to balance this picture and to provide a broad assessment of the future viability of these hospitals.[5] The article's conclusion—that, like our nation's health insurance coverage, this institutional safety net has gaps that are growing ever larger—should not be surprising. It mirrors closely the alarm sounded almost ten years ago by the American Hospital Association's Commission on Public General Hospitals.[6]

The difference in our nation's health system between ten years ago and today is truly striking. Ten years ago, hospital-industry inflation was running rampant, at times as high as 20% annually. Since then, however, actions by both governmental and third-party payers have dramatically cut back on the annual rate of increase in our nation's medical bill. Prospective payment systems have been undertaken by Medicare and many state Medicaid programs. Increasing numbers of physicians, often heavily in debt, have for the first time welcomed the security of salaried positions in health maintenance organizations and other alternative provision arrangements. Alternative financing and provision mechanisms have also been developed in the private sector.

These competitive and cost-containment burdens have fallen disproportionately most heavily on those hospitals least able to bear them. On the one hand, the failure to fill in the gaps in our nation's health insurance system has left huge segments of the population more vulnerable to medical indigency than ever before. (The ratio of Medicaid recipients to individuals living in poverty has been decreasing throughout the 1980s. In 1980, 54% of the below-poverty population was covered by Medicaid; by 1984, it is estimated that <40% of such individuals are covered [*Cost and Compassion: Recommendations for Avoiding a Crisis in Care for the Medically Indigent*. Chicago, American Hospital Association, 1986. See also *The Data Book: The Nation, States and Cities*. Washington, DC, The Children's Defense Fund, 1985].) On the other hand, the relentless competition to purchase health care services at the lowest possible price, eagerly pursued by public and private third-party payers alike, has served to reduce the revenue base available to finance this expanded demand. This has led in many areas to an increased need to rely on direct local tax subsidies. Yet, few of our nation's localities are able easily to meet this increased need.

The enormity of this burden, as well as the *fiscal* impact of *being* a "safety net" hospital, has been graphically documented in a series of recent American Hospital Association/Urban Institute surveys concerned with medical care for the poor.[7-10] These studies in particular have compared public and private hospitals in the 100 largest cities. The Urban Institute's dramatic comparative findings include the following: Urban public hospitals experience an annual average of $32 100 in bad debt/charity care per bed, a level 4½ times greater than for nonprofit institutions; urban public hospitals represent an estimated 5% of the hospital beds in the United States but provide 40% of all charity care; they provide almost twice as much Medicaid care as nonprofit hospitals; 50% of such hospitals incurred deficits on their bottom line (compared with 22% for urban nonprofit hospitals)—deficits that were five times higher on average than those of other community hospitals and were directly correlated with a high volume of low-income patients (J. Hadley, PhD, written communication, June 1984).

Patient Dumping—a Metaphor?

Another significant problem area for public hospitals identified in the *JAMA* articles and elsewhere[11] is inappropriate patient transfers, or "dumping," as it is less politely called. The patient transfer issue is a profound problem area, whose ramifications extend well beyond the emotional anecdotes and sensational news stories that typically mark public attention to this issue. In fact, the dumping problem must really be considered a metaphor for a wide range of problems, from inadequate access to insurance coverage, on the one hand, to the insensitivity of a "price competitive" health system to the need to guarantee that all essential health services will be available in our communities, regardless of the relative profitability of such services, on the other.

The dumping of patients by one hospital onto another is only one aspect of this problem, albeit an important one. And while federal and state regulators have intervened to protect patients against inappropriate dumping, experiences in several US cities have shown that this problem is also susceptible to solution through industry-wide cooperation, if we are prepared to acknowledge the problem.

To be sure, it must be accepted that patient transfers to public hospitals under some circumstances are perfectly appropriate. Providing services to indigent patients is usually one of the primary missions of an urban public hospital, and orderly mechanisms for enabling such hospitals to carry out this mission are desirable. But there must be appropriate rules for the operation of such mechanisms, for rarely is a public hospital able, or even legally required, to take *all* patient transfers.[12] Often, patients sought to be transferred are not, strictly speaking, indigent. Lower-income employed individuals who lack adequate insurance are typical examples. Nor is there ever a justification (legal or moral) for the transfer of an unstabilized patient—or, for that matter, a patient for whom a continuum of care has already begun in a private institution. It is these categories of inappropriate patient transfers at which recent new federal and state laws are primarily aimed.[13]

The Myth of Cost Shifting

It is often said that the patient transfer problem has been exacerbated by a dramatic reduction in cost shifting. To quote Princeton economist Uwe Reinhardt, "This now much maligned process of 'cost shifting' actually served as the fig-leaf that covered up what would have otherwise revealed itself to the world as a national disgrace. The fig-leaf, alas, appears to be slipping."[14] But a somewhat more cynical view, articulated recently in a forum at New York University by United Hospital Fund President Bruce Vladek, is that cost shifting for the purpose of financing indigent care and community-wide health services *never existed* in many hospitals. Rather, for most hospitals, cost shifting was useful only to reallocate the "categorical" shortfalls such hospitals perceived between their actual costs and the payments they were getting from Medicare and Medicaid. Extra money extracted from private insurers, over and above these "categorical" shortfalls, was simply brought to the bottom line, or spent on new equipment or facilities for paying patients, by most private hospitals. While the economic "burden" on private hospitals may therefore be greater today than it was a decade ago, this increased burden cannot be accepted as adequate justification for failing to treat patients today whom these hospitals never adequately served in the past.

For these reasons, the problem of increased hospital-to-hospital patient transfers should not be as difficult to solve as we might imagine. Moreover, the moral integrity of our nation's health system may be significantly enhanced if we can do so through industry-wide cooperation in developing patient transfer standards, based on protocols already established in cities like Dallas and Los Angeles, rather than having to rely exclusively on governmental constraints.

What About the 'Self-Dumped'?

The more profound problem we all must address, of course, is not dumping by hospitals, but rather "self-referrals" (or deferred care) by many individuals who know that most doors in our nation's health system are now closed to them and their families. The Robert Wood Johnson Foundation has estimated that, "At least 12 percent of the population, or 28 million persons, must be considered 'medically disadvantaged,' in that they lack health insurance, have no regular source of care, and tend to postpone needed care." (*Special Report: Updated Report on Access to Health Care for the American People*. Princeton, NJ, The Robert Wood Johnson Foundation, 1983.) While public hospitals will continue to fight against inappropriate or illegal transfer behavior by their private-sector counterparts, their doors will nevertheless remain open to these "self-referred" patients. But with many public hospitals operating at close to 100% capacity, this open-door policy may not be enough. Expanded coverage is ultimately the only feasible solution, although in the current budget environment, such a step is likely to require extraordinary political leadership and courage.

In the meantime, however, the Urban Institute has dramatically quantified the disproportionality of the current public hospital responsibility. Urban Institute researchers have identified upwards of $12.7 billion in charity care and bad debts actually provided by hospitals in our nation's 100 largest cities during 1982. And while $3.2 billion of this total was provided by private hospitals, $9.5 billion was funded by cities, counties, and non-Medicaid state appropriations, largely paid directly to governmentally owned hospitals.[15] This responsibility must continue to be met, and these hospitals must continue to be adequately funded and maintained.

The Capital Dilemma

But where will we get the capital to update and maintain this essential system of great public hospitals? One common fallacy about hospital-industry capital is that it is scarce. Nothing could be farther from the truth. Coffers are brimming today with money to lend to worthy projects. Of nearly $30 billion in tax-exempt bonds issued on behalf of hospitals in 1985—much of it to avoid end-of-year tax law changes—it is now estimated that nearly $6 billion may be returned to bondholders unspent.

The problem, however, is that the capital marketplace as it is presently constituted is essentially amoral. To equity investors and the tax-exempt bond market alike, the bottom line (and the interpretation of that bottom line by the bond-rating agencies) is God. Capital is therefore available to most hospitals purely on the basis of their relative profitability, which must be achieved through "customer" revenues rather than governmental subsidies. Profits required for even a barely adequate "investment grade" bond rating are likely to be far in excess of the profit margin needed to keep a typical governmentally supported hospital alive. Given a significant reduction in the ability of many cities or counties to use "general obligation" financing, a less amoral approach to capital financing for these important hospitals may soon be desperately needed.

A new federally supported capital access program for safety net hospitals should be adopted by Congress this year. This is by no means a radical proposal. Only last year, the Congress enacted such a program to benefit many of our nation's financially distressed universities.[16]

Are 'Politics' a Help or a Hindrance?

In conclusion, a few observations must be made about the "political problems" of public hospitals. In our experience, the quality and commitment of elected officials who take responsibility for health care financing and provision of service at the local level are often unappreciated. The entire public hospital sector suffers, in this respect, from attention to a few isolated situations.

Often the most serious *governmental* problem faced by a public hospital is financial, not political, involving a frankly unavoidable competition among local governmental services for funding. This competition is particularly fierce in economically depressed areas—which often have the greatest need for their public hospitals. However, we have found that local elected officials are virtually always sensitive to the relative importance of health care vis-à-vis other demands for the public dollar.

It is also simply a myth that most public hospitals in this country are less efficiently operated than their private-sector counterparts. For example, while occupancy rates in community hospitals have witnessed a dramatic decline, from 75% in 1975 to 69% in 1984 to 64.8% in 1985, National Association of Public Hospitals member hospital occupancy rates have increased and remain consistently high. During 1985, National Association of Public Hospitals member hospital occupancy rates averaged 80%. Again, isolated cases of governmental fraud or abuses are reported from time to time. However, such cases are by no means unknown in the private sector, where, indeed, public accountability is often far less for governmental dollars spent. It is true that procurement, civil service, and other bureaucratic constraints have long been identified with governmental ownership. But these constraints have already been alleviated in a number of cities around the country, through administrative or legal reorganizations, while in others they are relatively trivial in comparison with the large public investment required.

Finally, with regard to the quality of public hospital staff, it must be noted that despite the many physicians who no longer practice in the public hospitals that trained them, many outstanding medical and administrative personnel, who could easily find more lucrative positions elsewhere, nevertheless remain to serve in such hospitals. These individuals, as a group, are quite possibly the finest and most dedicated health care professionals in the nation. With their continued dedication, and with the strong support from those public and private health care decision makers who recognize the urgent need for these institutions, our nation's great public hospitals can continue to fulfill their vital mission.

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APPENDIX C

NAPH Member Hospitals

Alameda County Health Care Services Agency
Oakland, California
DAVID KEARS, Director

Alameda County/Fairmont Hospital
San Leandro, California
NEIL R. PETERSON, Administrator

Ben Taub General Hospital
Houston, Texas
MICHAEL BULLARD, Administrator

Bexar County Hospital District
San Antonio, Texas
JOHN A. GUEST, Executive Director

Boston Department of Health & Hospitals
Boston, Massachusetts
JUDITH KURLAND, Commissioner

Brackenridge Hospital
Austin, Texas
JOHN DANDRIDGE JR., Administrator

Charity Hospital at New Orleans
New Orleans, Louisiana
ELLIOTT C. ROBERTS, SR, Director

Contra Costa County Health Service Department
Martinez, California
MARK FINUCANE, Director

Cook County Hospital
Chicago, Illinois
RUTH ROTHSTEIN, Interim Executive Director

Cooper Green Hospital
Birmingham, Alabama
JOHN O. ROHDE, Chief Executive Officer

D.C. General Hospital
Washington, DC
MARK CHASTANG, Executive Director

Denver Health & Hospitals
Denver, Colorado
THOMAS MOE, Administrator (Acting)

E.A. Conway Memorial Hospital
Monroe, Louisiana
ROY D. BOSTICK, Director

Earl K. Long Memorial Hospital
Baton Rouge, Louisiana
STEVEN SMITH, Director

Erie County Medical Center
Buffalo, New York
GEORGE MCCOY, Administrator

Erlanger Medical Center
Chattanooga, Tennessee
JAMES C. PICKLE, President

Grady Memorial Hospital
Atlanta, Georgia
ROBERT B. JOHNSON Director

Harborview Medical Center
Seattle, Washington
DAVID C. TCH, Director

Harris County Hospital District
Houston, Texas
LOIS JEAN MOORE, Chief Executive Officer

Hennepin County Medical Center
Minneapolis, Minnesota
DANIEL B. MCLAUGHLIN, Administrator

Hilo Hospital
Hilo, Hawaii
JERRY MERRILL, Administrator

Honokaa Hospital
Honokaa, Hawaii YOSHITO IWAMOTO,
Administrator

Huey P. Long Regional Medical Center
Pineville, Louisiana
JAMES E. MORGAN, Director

Hurley Medical Center
Flint, Michigan
PHILLIP C. DUTCHER, Director

Jackson Memorial Hospital
Miami, Florida
IRA C. CLARK, Chief Executive Officer

Kau Hospital
Pahala, Hawaii
KENJI NAGAO, Administrator

Kauai Veterans Memorial Hospital
Kauai, Hawaii
KEITH HORINOUCHI, Administrator

Kern County Medical Center
Bakersfield, California
FLOYD E. FARLEY, Chief Operating Officer

Kohala Hospital
Kapaay, Hawaii
JACK O. HALSTEAD, Administrator

Kona Hospital
Kealakekua, Hawaii
JENNIE WUNG, Administrator

Kula Hospital
Kula, Hawaii
SHIRLEY TAKAHASI, Administrator

LAC*Harbor/UCLA Medical Center
Torrance, California
EDWARD J. FOLEY, Administrator

LAC*High Desert Hospital
Lancaster, California
WALTER L. GRAY, Administrator

LAC*KING-Drew Medical Center
Los Angeles, California
EDWARD J. RENFORD, Administrator

LAC*Olive View Medical Center
Sylmar, California
DOUGLAS D. BAGLEY, Administrator

LAC*Rancho Los Amigos Medical Center
Downey, California
ARMANDO LOPEZ, JR., Chief Executive Officer

LAC*USC Medical Center
Los Angeles, California
JERRY BUCKINGHAM, Executive Director

Lallie Kemp Regional Medical Center
Independence, Louisiana
THOMAS W. LANDRY, Chief Executive Officer

Lanai Community Hospital
Lanai City, Hawaii
MONICA BORGES, Administrator

Leahi Hospital
Honolulu, Hawaii
ABRAHAM L. CHOY, Administrator

LSU Medical Center
Shreveport, Louisiana
GENE L. HAMMETT, Administrator

Lyndon B. Johnson Hospital
Houston, Texas
MARGO HILLIARD ALFORD, Senior Vice President

Maluhia Hospital
Honolulu, Hawaii
GILBERT GIMA, Administrator

Maricopa County Medical Center
Phoenix, Arizona
BARBARA SAPP, Administrator

Maui Memorial Hospital
Wailuku, Hawaii
ALVIS CARR, Administrator

Medical Center of Central Georgia
Macon, Georgia
DAMON D. KING, Administrator

Memorial Hospital
Hollywood, Florida
FRANK V. SACCO, Chief Executive Officer

Merrithew Memorial Hospital
Martinez, California
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Metro Nashville General Hospital
Nashville, Tennessee
JOHN M. STONE, Chief Executive Officer

Milwaukee County Medical Complex
Milwaukee, Wisconsin
JULIE HANSER, Administrator

Moss Regional Hospital
Lake Charles, Louisiana
EDWARD G. POOR, Director

Nassau County Medical Center
East Meadow, New York
TRACY E. STREVEY, JR, MD, Chief Executive Officer

Northwest Texas Hospital
Amarillo, Texas
KEVIN J. GROSS, President

New York City Health & Hospital Corporation
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NYCHHC Bronx Municipal Hospital
Bronx, New York
PAMELA BRIER, Chief Executive Officer

NYCHHC City Hospital at Elmhurst
New York, New York
PETE VELEZ, Executive Director

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NYCHHC Harlem Hospital Center
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NYCHHC North Central Bronx
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EMILIO J. MORANTE, Executive Director

NYCHHC Queens Hospital Center
New York, New York
LORRAINE TREGDE, Executive Director

NYCHHC Woodhull Medical Health Center
Brooklyn, New York
CARLOS LORAN, Executive Director

Parkland Memorial Hospital
Dallas,
RON ANDERSON, MD, Chief Executive Officer

Phoebe Putney Memorial Hospital
Albany, Georgia
JOEL WERNICK, Chief Executive Officer

Pontiac General Hospital
Pontiac, Michigan
JAMES WRIGHT, President

Provident Health Services, Inc.
Savannah, Georgia
WILLIAM W. RIDDLE, JR, Chief Operating Officer

R.E. Thomason General Hospital
El Paso, Texas
JEFFREY BARBER, Chief Executive Officer

Regional Medical Center at Memphis
Memphis, Tennessee
LUCY SHAW, President

Riverside General Hospital
Riverside, California KENNETH B. COHEN, Administrator

Samuel Mahelona Memorial Hospital
Kapaa, Hawaii
JOHN ENGLISH, Administrator

San Bernardino County Medical Center
San Bernardino, California
CHARLES R. JERVIS, Director

San Francisco General Hospital
San Francisco, California
PHYLLIS J. HARDING, Acting Executive Administrator

San Joaquin General Hospital
Stockton, California
JEANETTE TAFT, Director

San Mateo County General Hospital
San Mateo, California
TIMOTHY B. MCMURDO, Chief Executive Officer

San Mateo County Health Department
San Mateo, California
MARGARET TAYLOR, Director

Santa Clara Valley Medical Center
San Jose, California
ROBERT SILLEN, Executive Director

South Louisiana Medical Center
Houma, Louisiana
WILLIAM MOHAN, Director

St. Louis Regional Medical Center
St. Louis, Missouri
SHERMAN MCCOY, President

St. Mary's Hospital
East St. Louis, Illinois
CHARLES E. WINDSOR, President

St. Paul-Ramsey Medical Center
St. Paul, Minnesota
MARLENE MARSCHALL, Director

SUNY Health Science Center
Syracuse, New York
JAMES L. ROSENBERG, Chief Executive Officer

Tampa General Hospital
Tampa, Florida
NEWELL E. FRANCE, Director

Tarrant County Hospital District
Fort Worth, Texas
TIM PHILPOT, Administrator

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Cincinnati, Ohio
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MARCIA TANNER WILSON, Director, Health Policy Development

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